Section 1915(b) Waiver

STATE OF NORTH CAROLINA

PIEDMONT CARDINAL HEALTH PLAN

Renewal

April 1, 2007 – March 31, 2009

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Proposal

Proposal for a Section 1915(b) Waiver
MCO, PIHP, PAHP, and/or PCCM Program

Face sheet

Please fill in and submit this Face sheet with each waiver proposal, renewal, or amendment request.

The **State** of North **Carolina** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is **PIEDMONT CARDINAL HEALTH PLAN**. (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

___ initial request for new waiver

___ amendment request for existing waiver, which modifies Section/Part _

__ Replacement pages are attached for specific Section/Part being amended

__ Document is replaced in full, with changes highlighted

X renewal request

__ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) are filled out.

X The State has used this waiver format for its previous waiver period.

Section A is ___ replaced in full

X carried over from previous waiver period. The State:

X assures there are no changes in the Program Description from the previous waiver period. **All of Section A is attached with updates on page 7 under "Tribal Consultation" and pages 7-8 "Program History." Updates are highlighted.**

__ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is ___ replaced in full

X carried over from previous waiver period. The State:

___ assures there are no changes in the Monitoring Plan from the previous waiver period.

X assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages. **All of Section B is**

attached with changed pages highlighted. Changes are found on pages 66 through 70, "Monitoring Strategies." Specifically, revisions to the following strategies were made: (c) Consumer Self-Report Data; (d) Data Analysis and Grievances/Appeals; (e) Enrollee Hotlines; (i) Measurement of Racial/Ethnic Disparities; (l) On-Site Reviews; (m) Performance Improvement Projects.

X The State has used this waiver format for its previous waiver period. Sections C and D are filled out.

Effective Dates: This waiver/**renewal**/amendment is requested for a period of 2 years; effective **April 1, 2007**and ending **March 31, 2009**.
(For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

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section A: Program Description

Part I: Program Overview

Piedmont Behavioral HealthCare is a public MH/DD/SAS organization serving a five-county region in North Carolina, including Cabarrus, Davidson, Rowan, Stanley and Union counties. The North Carolina public MH/DD/SAS system has traditionally delivered services through local "area authorities," which are political subdivisions of the State. This system is currently undergoing reform, which requires that the area authorities transition from providers of services to managers of services. Consistent with the philosophy in the President's "New Freedom" Commission Report, the reform requires that the State's local area authorities divest themselves of service provision and become Local Management Entities (LMEs) for all publicly funded MH/DD/SA services, including Medicaid funded services. Most services will be provided through the private sector, and LMEs will be responsible for authorizing and overseeing service provision. Piedmont has met the State's requirements and has been certified as a Local Management Entity.

Piedmont has developed an LME plan of operation which would ensure that services are provided in a prompt and efficient manner to those who need them. Piedmont's plan focuses on delivering services of the best quality; serving people in the context of finite resources; and assuring that individuals who want to remain in or return to their communities are able to do so. Piedmont has been at the forefront of MH/DD/SAS system reform, and the State of North Carolina proposes that Piedmont be given the authority to manage both services and funding and function for Medicaid purposes as a prepaid inpatient health plan (PIHP). As a prepaid health plan, Piedmont will recruit providers and develop and oversee a comprehensive MH/DD/SAS provider network that assures access to care for all enrollees. Piedmont will be paid per member, per month capitated payments and will be responsible for authorizing payments for services, processing and paying claims, and conducting utilization and quality management functions. As a prepaid health plan, Piedmont will be at financial risk for a discrete set of Mental Health, Developmental Disabilities and Substance Abuse services, including both Medicaid State Plan services and services contained in a new Home and Community Based Services waiver for persons with mental retardation and developmental disabilities. All age groups will be covered. ("Innovations", the new HCBS waiver, is being submitted along with this waiver request and will be a component of the Piedmont initiative.)

The Division of Medical Assistance (DMA), the State Medicaid Agency, will assure accountability and effective management of the waiver programs. DMA will retain

the responsibilities of approving all policies and requirements concerning the waiver.

The goals of The Piedmont Cardinal Plan initiative are to:

- **Better tailor services to the local consumers by adopting a consumer-directed care model and focusing on community-based rather than facility-based care.**
- **Enhance consumer involvement in planning and providing services through the proliferation of Mental Health Recovery Model concepts.**
- **Demonstrate that care can be provided more efficiently with increased local control.**

Tribal consultation

For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

The Eastern Band of Cherokee is the only federally recognized tribe with tribal lands in North Carolina. The tribal lands are located in five counties in the far western part of the State near Tennessee. The Piedmont counties included in this project are located in central North Carolina. Please note, however, that a public process with significant opportunity for public comment by individuals of all races and ethnicities was utilized in designing the framework for the Piedmont program. A series of local forums to obtain input from all stakeholders was conducted, and a consumer family advisory committee was established to ensure consumer input to both the planning process and the ongoing operation of the program. A website was also developed which provided information about Piedmont's plan and a feedback link for public comments. During its first two years of operation, the Piedmont Plan has maintained open communication with consumers, providers and other stakeholders through consumer and provider satisfaction surveys, complaints tracking and analysis, and active consumer affairs and community relations offices. Outreach, cultural sensitivity and coordination with community resources for the best possible consumer outcomes are the central focus of the consumer affairs and relations offices. As described in detail in Section C, Monitoring Results, stakeholder feedback is incorporated for system improvement.

Program History

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

The Piedmont Cardinal Health Plan (PCHP), which operates concurrently with a 1915 (c) waiver, Innovations, was implemented in the five Piedmont counties on April 1, 2005. PCHP is operated by Piedmont Behavioral Healthcare (PBH), a local government entity

that manages publicly funded mental health, developmental disabilities and substance abuse services. All Medicaid participants in the eligibility groups covered under the waiver were mandatorily enrolled in the single PIHP on April 1.

Implementation of PCHP coincided with two major initiatives: transition of the public MH/DD/SAS area programs into management entities and redesign of the state's Medicaid MH/DD/SAS service package. The State's public MH/DD/SAS system has traditionally delivered services through local "area authorities"; however, the system has been undergoing reform over the past few years to transition the area authorities from providers to managers of services. The Piedmont PIHP divested of services and made the transition to a "local management entity" during the year preceding waiver implementation. The second major system change, implementation of the State's new MH/DD/SAS benefit package, took place in a very short timeframe during the first year of waiver operation, from January through March of 2006. Implementation was a challenge for the entire state but particularly so for PCHP given its new structure as an at-risk managed care entity.

During its first year of operation, it was determined that PCHP had generated savings through care and utilization management strategies, and the state requested and received approval from CMS in December of 2006 to invest the savings in 1915(b)(3) services for PCHP Medicaid recipients. The b3 service package contains cost-effective, supplemental services and supports aimed at decreasing hospitalizations and helping individuals remain in their homes and communities when preferred and appropriate. The b3 services will be implemented pending amendment and CMS approval of the risk contract.

The Piedmont waiver program exists in a dynamic environment and continues to evolve and grow as a managed care entity. The program has been closely scrutinized during its first two years of operation through mandatory EQRO activities, an Independent Assessment, the Intra-departmental monitoring team and an on-site review of operations. As described in Section C "Monitoring Results", feedback from these review and oversight activities have been (and will continue to be) used for system improvements.

A. Statutory Authority

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

a.___ **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.

b. ___ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.

c. _X_ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.

d. **X 1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

The 1915(b)(4) waiver applies to the following programs

___ MCO
X PIHP
___ PAHP
___ PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
___ Other (please identify programs)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

a. X **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

b. **X** **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.

c. **X** **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.

d. **X** **Section 1902(a)(4) -** To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If State seeks waivers of additional managed care provisions, please list here).

e.___ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

B. Delivery Systems

1. **Delivery Systems**. The State will be using the following systems to deliver services:

a.___ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b. **X** **PIHP:** Prepaid Inpatient Health Plan means an entity that:
(1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

X The PIHP is paid on a risk basis.
___ The PIHP is paid on a non-risk basis.

Piedmont Behavioral Healthcare is a PIHP for Mental Health and Substance Abuse services. A 1915b/c waiver for the Piedmont MR/DD population is being submitted with this waiver and Piedmont will deliver these services through the PIHP as well. Therefore, Piedmont will be at risk for mental health and substance abuse services, including inpatient, clinic option and rehabilitation option services, and Home and Community Based Services under the "Innovations" waiver.

c.___ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3)
does not have a comprehensive risk contract. This includes capitated PCCMs.

___ The PAHP is paid on a risk basis.
___ The PAHP is paid on a non-risk basis.

d.___ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e.___ **Other:** (Please provide a brief narrative description of the model.)

2. **Procurement**. The State selected the contractor in the following manner (required by 42 CFR Part 74 if contract over $100,000). Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

___ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
___ **Open** cooperative procurement process (in which any qualifying contractor may participate)
X **Sole source** procurement. CMS Regional Office prior approval required.

Prior approval of sole source procurement is requested based on the following information:

Justification for Sole Source to Piedmont

The North Carolina General Assembly, in Session Law 2001-437, (codified at NC Gen. Stat. 122C) mandates that the Department of Health and Human Services implement comprehensive reforms to the State's public MH/DD/SA system. The statute, and corresponding "Blueprint for Change" adopted by DHHS, designates the local mental health Authorities as the "locus of coordination" for the provision of all publicly funded MH/DD/SA services.

The goal of the North Carolina State Reform is to have one local system manager that manages the complexities of the myriad State, Federal, County and Medicaid funds to ensure access to a seamless system of care for people with Mental Health, Developmental Disabilities and Substance Abuse needs. This objective can best be accomplished through a managed system in which the consumer has access, through a single local entity, to all resource streams (Medicaid, State/Federal, and County) that finance services and supports needed by consumers. This local management must bring together multiple policies, programs and payment resources and reconcile differing eligibility requirements in order to achieve optimal outcomes. Consumers with serious mental illness, developmental disabilities and addictive disorders need highly specialized assistance, distinctive care management strategies, specialized interventions and highly individualized support

arrangements that are not typically available from or covered by other payers and managed care systems. The coordination of these services requires collaboration and cooperative relationships among many agencies, including public health, social services, housing, education, criminal justice, and others. Managing care for these consumers requires a high degree of specificity, organization and integration of its management system, including dedicated programs, transaction-specific facilities, and a specialized workforce. There must be a strong, ongoing, and collaborative relationship between the purchaser and the providers in order to achieve the necessary investment to support these services at the provider level.

Inherent in North Carolina's model is the assumption that its local public Mental Health, Developmental Disabilities, and Substance Abuse Authorities are the only organizations capable of managing the complex service and support needs of the specialty population, at least during these initial stages of the comprehensive reform. These public entities are political subdivisions of the State under North Carolina General Statute 122-C and most have been in place over 30 years. The Authorities have had the ongoing role of protecting vulnerable populations and supporting full participation and inclusion of these consumers in local communities. This is possible due to the local systems and relationships that they have developed over a long period of time. The infrastructure for managing services and supports for these populations is already in place.

These local public Authorities are divesting themselves of direct service provision to foster the development of more and varied private providers, increasing access and choice for consumers. The local Authority must coordinate with other local agencies and stakeholders to organize resources (specialized and generic) and effectively connect consumers and families with appropriate community services and supports. These efforts are expected to achieve greater system efficiency, improve access for consumers, develop a more comprehensive array of provider choices and levels of care, increase provider to provider collaboration and coordination, while reducing instances of ineffective, inefficient, or wasteful use of limited public resources. The key to achieving these goals involves assigning a "locus of coordination and authority" to a local public entity, charged by State statute, its consumers, and the community at large with organizing a system of services and supports that is more responsive and highly accountable to funders, other systems requiring behavioral health services, and providers. The local Authorities have been identified as the "locus of coordination" because the nature of this stage of the reform process requires efforts that are only possible because of the local Authority's decades of experience as the "safety net" for individuals with MH/DD/SA needs, many years of work establishing critical collaborative local relationships, and the ability to apply their specialized knowledge to inherently unique characteristics of local communities.

Private managed care organizations, with the necessary capacity, essential localized experience and relationships, and incumbent public behavioral healthcare expertise, are virtually nonexistent in North Carolina. The vast majority of North Carolina's employer

based health care purchasers have chosen not to furnish benefits through managed care organizations. A specialized behavioral health managed care vendor provides limited, paper-transaction-based utilization review of some behavioral health services once an individual's utilization exceeds certain thresholds. DHHS is in the process of re-procuring these services. The State and local Authorities have always held all of the financial risk and public accountability for public behavioral healthcare services in North Carolina. Consumers, local elected officials, State lawmakers and policymakers – none of these groups has determined that a private managed care organization can successfully and quickly implement the reform-driven business model in a manner that will be locally responsive and consistent with local, State, and Federal requirements.

State law redirects the mission of the local Authorities from being primarily providers of MH/DD/SA direct services to the role of delivery system manager. Each local Authority is required to work with the area's consumers, family members, citizens at large, providers, other community stakeholders, and other systems' local Authorities to develop a local business plan for the management, delivery and oversight of publicly funded MH/DD/SA services. The local Authorities are required to contract with "qualified public or private providers, agencies, institutions, or resources …" to ensure that core or basic MH/DD/SA services are available locally and that individuals, particularly those considered to have high-needs, are identified and receive the appropriate services. The emphasis is to empower consumers and to provide a choice of providers and services that most significantly impact the person's life, rather than a choice of plan administrators. A single plan administrator within a region will achieve greater administrative efficiencies, and more funding for services to consumers.

The local Authority must arrange an accessible screening, triage, and referral system, provide for changes in the Authority's governance (including establish a Consumer and Family Advisory Committee), assure that services and supports are being delivered pursuant to the consumer-developed Person Centered Plan, monitor providers, encourage the development of coordination/affiliation arrangements among private providers serving consumers with public funds, perform quality improvement activities, incorporate local conditions and needs in plans to purchase services, and provide mechanisms to enable North Carolinians living in institutions to have access to appropriate services necessary to enable them to live in the community, if the consumer so chooses. Local Authorities are required to accomplish this system coordination and management by performing a number of identified administrative functions, in a manner that ensures maximum coordination of public MH/DD/SA funds and resources, in ways that are responsive to unique local needs, and to do so while complying with Federal and State funding requirements (including 42 USC 1396a, et. seq.).

The "Local Business Plan" sets forth how the Authority will meet these responsibilities. Local Authorities submit these Local Business Plans to their county commissioners, who by resolution approve and adopt the plan. In turn, the local Authority submits the approved

Local Business Plan to the Division of MH/DD/SAS, which determines if the plan demonstrates that the local Authority has the capacity to perform the administrative functions required of a "Local Management Entity." Local Authorities meeting all of these requirements are then certified by the Department of Health and Human Services as "Local Management Entities" (LMEs).

Developing the fulcrum of LME functionality involves a highly participatory, local and public process involving individuals and agencies throughout the communities served. To be successful, an LME must make significant investments that are directed by that community, through the public governance model, in ways that meet State and Federal requirements. Inherent in this arrangement is the State's determination that local Authorities are best situated, at this stage of the overall system reform, to perform the roles of an LME. This model is how North Carolina has chosen to meet the goals. Piedmont Behavioral HealthCare, the five-county local Authority to which this waiver request refers, has submitted its approved local business plan, and is certified as an LME. Piedmont has entered into a performance agreement with DHHS to assume responsibility for the local management of all State and local public funding for MH/DD/SA services. The agreement requires that a comprehensive array of public resources be coordinated to the greatest extent possible to increase access, improve quality, and realize savings by removing barriers to consumers' ability to achieve Resilience, Recovery, and/or Self-Determination while living in the community.

Piedmont has been selected by the State to apply this innovative approach to Medicaid services, under this Waiver application. Pursuant to its LME certification, Piedmont Behavioral HealthCare will arrange for the provision of all MH/DD/SA services purchased with public funds on behalf of individuals residing in its five county area. The State wants to include Medicaid MH/DD/SA services within the array of resources being coordinated by the Piedmont LME; accordingly, and in light of the absence of other entities with the requisite capacity and local experience, the State has selected the Piedmont LME as the PIHP for the 1915b waiver. Savings achieved under this waiver will not be used for non-Medicaid consumers, but will be reinvested back into services for Medicaid consumers through an approved reinvestment plan.

Throughout the waiver period, the State will continue its efforts to identify any other entities that may come to have developed the capacity to 1) coordinate all of the public resources; 2)address the unique characteristics of North Carolina's diverse local communities through collaboration with community-based stakeholders; 3) adhere to the principles of North Carolina's Blueprint for Change and the goals of the New Freedom Commission; and 4) are found to be acceptable by the local community's Consumer and Family Advisory Committee. If such entities are identified, the State will examine whether the compelling justification for a sole source during this initial period of the waiver continues to exist in subsequent renewal periods.

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. **Assurances.**

___ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

X The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

Piedmont Behavioral HealthCare is a local mental health Authority and has provided and coordinated publicly funded MH/DD/SA services for over 30 years. The North Carolina General Assembly, in Session Law 2001-437, designated the local area Authorities as the "locus of coordination" for the provision of all publicly funded MH/DD/SA services. Under these circumstances, the State does not believe that making only one plan available will negatively impact recipients' access to care. On the other hand, the State believes that Piedmont is in a unique position to bring together the services and supports, both formal and informal, and providers, both professional and paraprofessional, that are needed to meet the complex needs of these populations. Piedmont has decades of experience locating and developing services for consumers with MH/DD/SAS needs, and over the years, Piedmont has built strong and collaborative working relationships with the providers of these services. These providers support this initiative and consumers will have at least as much choice in individual providers as they have today in a non-managed care environment. By delivering, managing and paying for services through this one public entity with the appropriate experience, the State expects to streamline and simplify the delivery system; better identify those in need of services as well as their level of need; and achieve a savings which Piedmont, as a public entity, will reinvest in the system. Private managed care organizations with this type of experience and relationships with local human service agencies and facilities are largely nonexistent in North Carolina.

2. **Details**. The State will provide enrollees with the following choices (please replicate for each program in waiver):

___ Two or more MCOs
___ Two or more primary care providers within one PCCM system.
___ A PCCM or one or more MCOs
___ Two or more PIHPs.
___ Two or more PAHPs.

X Other: (please describe)

Enrollees will have free choice of providers within the PIHP and may change providers as often as desired. If an individual joins the PIHP and is already established with a provider who is not a member of the network, Piedmont will make every effort to arrange for the consumer to continue with the same provider if the consumer so desires. In this case, the provider would be required to meet the same qualifications as other providers in the network. In addition, if an enrollee needs a specialized service that is not available through the network, Piedmont will arrange for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, enrollees will be given the choice between at least two providers. Exceptions would involve institutional services or highly specialized services which are usually available through only one facility or agency in the geographic area.

3. **Rural Exception.**

___ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the **following areas** ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

D. Geographic Areas Served by the Waiver

1. **General**. Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

___ **Statewide** -- all counties, zip codes, or regions of the State

X **Less than Statewide**

2. **Details**. Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Piedmont Region **(Which includes the following counties: Cabarrus, Davidson, Rowan, Stanly and Union)**	**PIHP**	**Piedmont Cardinal Health Plan**

E. Populations Included in Waiver

1. **Included Populations**. The following populations are included in the Waiver Program:

X Section 1931 Children and Related Populations are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

X Mandatory enrollment
___ Voluntary enrollment

X Section 1931 Adults and Related Populations are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

X Mandatory enrollment
___ Voluntary enrollment

X Blind/Disabled Adults and Related Populations are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

X Mandatory enrollment
___ Voluntary enrollment

X Blind/Disabled Children and Related Populations are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

X Mandatory enrollment
___ Voluntary enrollment

X Aged and Related Populations are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

X Mandatory enrollment
___ Voluntary enrollment

X Foster Care Children are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

X Mandatory enrollment
___ Voluntary enrollment

___ **TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

___ Mandatory enrollment
___ Voluntary enrollment

The following groups are also included:

- **Optional categorically needy families and children and all medically needy individuals**
- **Medicaid for Infants and Children**
- Special Assistance for the Disabled (SAD) and Special Assistance for the Aged (SAA)
- Medicaid for Pregnant Women (MPW)
- Persons receiving refugee assistance (MRFMN, RRFCN, MRFNN)

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

___ **Medicare Dual Eligible--**Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

___ **Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

___ **Other Insurance--**Medicaid beneficiaries who have other health insurance.

___ **Reside in Nursing Facility or ICF/MR--**Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

___ **Enrolled in Another Managed Care Program--**Medicaid beneficiaries who are enrolled in another Medicaid managed care program

___ **Eligibility Less Than 3 Months--**Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

___ **Participate in HCBS Waiver**--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

___ **American Indian/Alaskan Native**--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

___ **Special Needs Children (State Defined)**--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

X SCHIP Title XXI Children – Medicaid beneficiaries who receive services through the SCHIP program.

X Retroactive Eligibility – Medicaid beneficiaries for the period of retroactive eligibility.

X Other (Please define):

- **Qualified Medicare Beneficiary groups (MQ-B, E, and Q)**
- **Children ages 0 to 3 years, except that all age groups may participate in the HCBS waiver, "Innovations"**
- **Non-Qualified aliens or qualified aliens during the five-year ban**

F. Services

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. **Assurances.**

X The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b) **(Not applicable to this behavioral health plan)**

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement. (See note below for limitations on requirements that may be waived).

__X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable, and these contracts are effective for the period April 1, 2005 to March 31, 2007 (with an option for a one year extension).

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

___ The PIHP or PAHP does not cover emergency services.

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

___ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services
___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers
___ The State will pay for all family planning services, whether provided by network or out-of-network providers.
___ Other (please explain):

X Family planning services are not included under the waiver.

4. **FQHC Services**. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

___ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.
___ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

X The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

5. **EPSDT Requirements.**

X The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

Treatment for MH/SA Conditions identified in EPSDT screenings will be furnished through the Piedmont PIHP. Agencies conducting the screenings will coordinate with the Piedmont PIHP and service providers.

6. **1915(b)(3) Services.**

_X_This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

These services are in addition to and are not duplicative of other services available under the State Plan, EPSDT, IDEA or Rehabilitation Act of 1973. Payments for these services will be made in accordance with State policy.

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
Respite Provided when the primary care giver needs temporary relief from care-giving responsibilities and the child with mental health, developmental disability or substance abuse diagnosis or adult with developmental disabilities has limitations in adaptive skills that require supervision in the absence of the primary caregiver; and there are not other natural resources and supports available to the primary caregiver to provide the necessary relief or substitute care. A maximum of sixty-four (64) units (sixteen (16) hours a day) can be provided in a twenty-four (24) hour period. No more than 1,536 Units (384 hours or 24 days) can be provided to an individual in a calendar year unless specific authorization for exceeding this limit is approved.	Children (younger than 21 years old) with a mental health, developmental disability or substance abuse diagnosis who do not live in a child residential treatment facility and adults (age 21 and older) with a current diagnosis of a developmental disability and who: (1) meet the functional eligibility requirements for the Piedmont Innovations 1915(c) waiver program but are not enrolled; OR (2) are not functionally eligible for the Piedmont Innovations Waiver Program but require continuous supervision due to at least one identified disability defined below: (a) CALOCUS level III or greater and ASAM criteria of II.1 or greater (b) Axis I or II diagnosis present (c) A current diagnosis of a developmental disability and, for adults with developmental disabilities, have a score of 102 or below on the Supports Intensity Scale.	Providers must meet the Piedmont Innovations waiver's (1) provider requirements, (2) state licensure requirements, (3) certification requirements and (4) other requirements and standards Respite Care shall not provided by any individual who resides in the child or adult's primary place of residence	Entire Piedmont service area (Cabarrus, Davidson, Rowan, Stanly and Union counties) Total expenditures on Respite, Crisis Respite, Supported Employment, Individual Support, Community Transition Services, and Peer Supports statewide cannot exceed 1915(b)(3) resources available in the waiver, defined by the State as up to $7,942,083 or $10.50 PMPM in P1 and $8,526,968 or $11.27 PMPM in P2.	For payment purposes, reimbursement for this service will be made as part of the total PIHP capitation payment; however, separate state plan and (b)(3) service rates will be developed. The State's actuary will certify separately to the state plan and (b)(3) rates.

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
Crisis Respite Crisis Respite is a short-term service that cannot be provided for more than thirty (30) days in a twelve (12) month period. The maximum length of stay is 10 days.	Children under the age of 21 years who do not live in a child residential treatment facility and who have: (1) CALOCUS level III or greater or ASAM criteria level II.1 or greater; and (2) Axis I or II diagnosis present, other than sole diagnosis of developmental disability; and (3) Imminent risk for PRTF/psychiatric hospitalization if not in receipt of Crisis Respite services. Children receiving this service cannot be enrolled in the Piedmont Innovations Program.	Facility providers must meet requirements in the Residential Treatment Level II-Family Type licensure requirements. Facilities must be licensed under the Division of Social Services 131-D family setting homes. Qualified Professional (QP) or Associated Professionals (AP) providers must meet 10A NCAC 27G.0104 Associate Professionals (AP) and Paraprofessional level providers must meet requirements in 10 NCAC 27G 0104 and must be supervised by a Qualified Professional according to 10A NXCAC 27G .0204 All Staff must meet training requirements as specified in State policy. Providers must ensure access to Licensed Professionals 24 hours a day, 7 days a week as needed to provide necessary clinical support.	Entire Piedmont service area (Cabarrus, Davidson, Rowan, Stanly and Union counties) Total expenditures on Respite, Crisis Respite, Supported Employment, Individual Support, Community Transition Services, and Peer Supports statewide cannot exceed 1915(b)(3) resources available in the waiver, defined by the State as up to $7,942,083 or $10.50 PMPM in P1 and $8,526,968 or $11.27 PMPM in P2.	For payment purposes, reimbursement for this service will be made as part of the total PIHP capitation payment; however, separate state plan and (b)(3) service rates will be developed. The State's actuary will certify separately to the state plan and (b)(3) rates.

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
Supported Employment Initial job development, training and support: A maximum of 86 hours (344 units) per month for the first 90 days; Intermediate training and support: a maximum of 43 hours (172 units) per month for the second 90 days; Long Term support: a maximum of 10 hours (40 units) per month Specific authorization must be obtained to exceed these limits.	Persons age 16 and older, who are not eligible for this service under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142, and who: (1) meet the functional eligibility requirements for the Piedmont Innovations 1915(c) waiver program but are not enrolled; OR (2) meet one of the following: (a) there is an Axis I or II diagnosis present and the person meets Level of Care Criteria for LOCUS Level II or ASAM III; (b) the person has a diagnosed developmental disability as defined in GS 122C-3 (12a) and has significant deficits in one or more functional life areas and, for adults (age 21 and older), a score of 102 or below on the Supports Intensity Scale. Children (age 16 or older but under age 21) who are residing in a Medicaid funded group residential treatment facility are not eligible for this service.	Providers must meet the Piedmont Innovations waiver's (1) provider requirements, (2) state licensure requirements, (3) certification requirements and (4) other requirements and standards In addition, providers must meet the following: *Minimum Staff Requirements:* Bachelors Degree in a human services field; or high school with five years of experience in the general workforce, two of which working directly with consumers that have behavioral health or developmental disabilities. *Staff Supervision Requirements:* Qualified Professional	Entire Piedmont service area (Cabarrus, Davidson, Rowan, Stanly and Union counties) Total expenditures on Respite, Crisis Respite, Supported Employment, Individual Support, Community Transition Services, and Peer Supports statewide cannot exceed 1915(b)(3) resources available in the waiver, defined by the State as up to $7,942,083 or $10.50 PMPM in P1 and $8,526,968 or $11.27 PMPM in P2.	For payment purposes, reimbursement for this service will be made as part of the total PIHP capitation payment; however, separate state plan and (b)(3) service rates will be developed. The State's actuary will certify separately to the state plan and (b)(3) rates.

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
Individual Support Units are provided in 15-minute increments. No more than 240 units per month (60 hours per month) of Individual Support may be provided unless specific authorization for exceeding this limit is approved. Individual Support is not covered under the Innovations waiver and is a "hands-on" service for persons with severe and persistent mental illness, a population that is not covered under the Innovations waiver. The intent of the service is to teach and assist individuals in carrying out instrumental activities of daily living, such as preparing meals, managing medicines, grocery shopping, and managing money, so they can live independently in the community. We envision that the need for the service will "fade" or decrease over time as the individual becomes capable of performing some of these activities more independently.	Adults ages 18 and older with a diagnosis of Severe and Persistent Mental Illness and a LOCUS level of II or greater. Persons between the ages of 18 and 21 may not live in a Medicaid funded child residential treatment facility.	Paraprofessional staff employed by the contracted provider and supervised by that provider's appropriate Qualified Professional. The Paraprofessional must have a high school degree and two years of experience working with adults with mental illness. A minimum of 20 hours of initial training will be required. Provider may not be a family member	Entire Piedmont service area (Cabarrus, Davidson, Rowan, Stanly and Union counties) Total expenditures on Respite, Crisis Respite, Supported Employment, Individual Support, Community Transition Services, and Peer Supports statewide cannot exceed 1915(b)(3) resources available in the waiver, defined by the State as up to $7,942,083 or $10.50 PMPM in P1 and $8,526,968 or $11.27 PMPM in P2.	For payment purposes, reimbursement for this service will be made as part of the total PIHP capitation payment; however, separate state plan and (b)(3) service rates will be developed. The State's actuary will certify separately to the state plan and (b)(3) rates.

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
Community Transition Services As under the Innovations Program, one-time funds are available up to $5,000. Funds may be expended over a 90 day period that commences 30 days prior to the scheduled move date.	Adults age 18 and older, who: (1) meet the functional eligibility requirements for the Piedmont Innovations 1915(c) waiver program but are not enrolled; OR (2) meet one of the following: (a) there is an Axis I or II diagnosis present and the person meets Level of Care Criteria for LOCUS or CALOCUS Level III or greater or ASAM III.1 or greater; (b) The person has a diagnosed developmental disability as defined in GS 122C-3 (12a) and has significant deficits in one or more functional life areas and a score of 102 or below on the Supports Intensity Scale The individual must be moving out of a licensed facility, their family home, hospital or institution into his or her own home.	Providers must meet the Piedmont Innovations waiver's (1) provider requirements, (2) state licensure requirements, (3) certification requirements and (4) other requirements and standards	Entire Piedmont service area (Cabarrus, Davidson, Rowan, Stanly and Union counties) Total expenditures on Respite, Crisis Respite, Supported Employment, Individual Support, Community Transition Services, and Peer Supports statewide cannot exceed 1915(b)(3) resources available in the waiver, defined by the State as up to $7,942,083 or $10.50 PMPM in P1 and $8,526,968 or $11.27 PMPM in P2.	For payment purposes, reimbursement for this service will be made as part of the total PIHP capitation payment; however, separate state plan and (b)(3) service rates will be developed. The State's actuary will certify separately to the state plan and (b)(3) rates.

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
Peer Supports Authorizations will be made as follows: • Initial authorization: First 90 days (or when a person is experiencing a period of instability): No more than 15 hours per week. • Step down to Sustaining Support: After first 90 days and up to subsequent 90-days No more than 10 hours per week except when necessary to address short-term problems/issues • Intermittent support: After 180 days, no more than 5 hours per week A maximum of sixteen (16) units of Peer Support services can be provided in a 24-hour period by any one Peer Support staff. No more than 60 units per week of services can be provided to an individual. If medical necessity dictates the need for more service hours, consideration should be given to interventions with a more intense clinical component; additional units may be authorized as clinically appropriate.	Adults ages 18 and older with identified needs in life skills, who: (1) have an Axis I or II diagnosis present; and (2) meet Level of Care Criteria for LOCUS Level I or ASAM I. Persons ages 18 to 21 may not live in a child residential treatment facility.	North Carolina Certified Peer Support Specialists and Paraprofessionals, who: (1) possess a high school degree or GED equivalent; and (2) are supervised by a Qualified Professional according to 10A NXCAC 27G .0204; and (3) are not a member of the family of the person receiving Peer Supports services. Paraprofessional level providers must meet requirements in 10 NCAC 27G 0104.	Entire Piedmont service area (Cabarrus, Davidson, Rowan, Stanly and Union counties) Total expenditures on Respite, Crisis Respite, Supported Employment, Individual Support, Community Transition Services, and Peer Supports statewide cannot exceed 1915(b)(3) resources available in the waiver, defined by the State as up to $7,942,083 or $10.50 PMPM in P1 and $8,526,968 or $11.27 PMPM in P2.	For payment purposes, reimbursement for this service will be made as part of the total PIHP capitation payment; however, separate state plan and (b)(3) service rates will be developed. The State's actuary will certify separately to the state plan and (b)(3) rates.
Innovations Waiver Services (same as those provided under the Piedmont Innovations program but not included above) • Augmentative Communication Services • Caregiver Training and Education • Crisis Services • Financial Management Services • Day Supports • Home and Community Supports • Residential Supports • Home Modifications • Individual Directed Goods and Services • Individual Training and Education Services • Personal Assistance Services • Specialized Consultation Services • Specialized Equipment and Supplies • Supports Brokerage • Vehicle Adaptation	Children and adults (over the age of 3), who meet the functional eligibility requirements for the Piedmont Innovations 1915(c) waiver program but are not enrolled and are moving out of an ICF/MR.	Providers must meet the Piedmont Innovations waiver's (1) provider requirements, (2) state licensure requirements, (3) certification requirements and (4) other requirements and standards	Entire Piedmont service area (Cabarrus, Davidson, Rowan, Stanly and Union counties) Total expenditures on Innovations Waiver Services (for persons not enrolled in the Piedmont Innovations waiver program) statewide cannot exceed 1915(b)(3) resources available in the waiver, defined by the State as up to $3,309,201 or $4.37 PMPM in P1 and $3,552,903 or $4.70 PMPM in P2.	For payment purposes, reimbursement for this service will be made as part of the total PIHP capitation payment; however, separate state plan and (b)(3) service rates will be developed. The State's actuary will certify separately to the state plan and (b)(3) rates.
Community Reinvestment Fund	Determined on a case-by-case basis and prior approved by CMS RO	Determined on a case-by-case basis and prior approved by CMS RO	Determined on a case-by-case basis and prior approved by CMS RO	Determined on a case-by-case basis and prior approved by CMS RO

Total expenditures on Respite, Crisis Respite, Supported Employment, Individual Support, Community Transition Services, Peer Supports, and Innovations Waiver Services (for persons not enrolled in the Piedmont Innovations program) statewide cannot exceed 1915(b)(3) resources available in the waiver, defined by the State as up to $11,251,284 or $14.87 PMPM in P1 and $12,079,872 or $15.96 PMPM in P2.

7. **Self-referrals.**

___The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Section A: Program Description

Part II: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

A. Timely Access Standards

1. **Assurances for MCO, PIHP, or PAHP programs.**

X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

The State seeks a waiver a waiver of section 1902(a)(4) of the Act, to waive compliance with of one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services and these contracts are effective for the period April 1, 2005 to March 31, 2007 (with an option for a one year extension).

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

2. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses to assure timely access to services.

a. ___ **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Hospitals (please describe):

6.___ Mental Health (please describe):

7.___ Pharmacies (please describe):

8.___ Substance Abuse Treatment Providers (please describe):

9.___ Other providers (please describe):

b. ___ **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Urgent care (please describe):

8.___ Other providers (please describe):

c. ___ **In-Office Waiting Times**: The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Other providers (please describe):

d. ___ **Other Access Standards** (please describe)

B. Capacity Standards

1. **Assurances for MCO, PIHP, or PAHP programs.**

X The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services and these contracts are effective for the period April 1, 2005 to March 31, 2007 (with an option for a one year extension).

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

2. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a.___ The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.

b.___ The State ensures that there are adequate number of PCCM PCPs with **open panels**. Please describe the State's standard.

c.___ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.

d.___ The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Pediatricians			
Family Practitioners			
Internists			
General Practitioners			
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to be in PCCM			
1			
2.			
3.			
4.			

*Please note any limitations to the data in the chart above here:

e.___ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.

f.___ **PCP:Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a Statewide average. Please note any changes that will occur due to the use of physician extenders.

Area(City/County/Region)	*PCCM-to-Enrollee Ratio*
Statewide Average: (e.g. 1:500 and 1:1,000)	

g. ___ **Other capacity standards** (please describe):

C. Coordination and Continuity of Care Standards

1. **Assurances For MCO, PIHP, or PAHP programs.**

X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care and these contracts are effective for the period April 1, 2005 to March 31, 2007 (with an option for a one year extension).

2. **Details on MCO/PIHP/PAHP enrollees with special health care needs**.

The following items are required.

a. **X** The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

As a behavioral health carve-out, the services under the waiver are specialty services and are designed for persons with special needs, some more intense than others. The waiver will serve persons with developmental disabilities, severe psychiatric diagnoses such as schizophrenia, and substance abuse disorders, in addition to individuals who have one-time or short-term needs such as psychotherapy due to a personal concern. When an individual requests services, a determination is made as to intensity of need. Treatment plans containing a variety of services and supports are developed for everyone who needs ongoing services. Issues around identification of persons with special needs do not appear to be relevant to this application as all enrollees are considered to have special needs in varying intensities.

b. ___ **Identification**. The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

c. ___ **Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

d.____**Treatment Plans**. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

1.__ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

2. Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

3. In accord with any applicable State quality assurance and utilization review standards.

e.____**Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees. **N/A**

a. ___ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.

b. ___ Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.

c. ___ Each enrollee is receives **health education/promotion** information. Please explain.

d. ___ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.

e. ___ There is appropriate and confidential **exchange of information** among providers.

f. ___ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.

g. ___ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

h. ___ **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).

i. ___ **Referrals**: Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

Section A: Program Description

Part III: Quality

1. **Assurances for MCO or PIHP programs**.

X The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one of more of these regulatory requirements for its PIHP program. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 and these contracts are effective for the period April 1, 2005 to March 31, 2007 (with an option for a one year extension).

X Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this **quality strategy** was submitted to the CMS Regional Office on **the date of submission of this waiver request.**

X The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO				
PIHP	Michigan Peer Review Organization (MPRO)	X	Validation of Performance Measures; Validation of Performance Improvement Projects; On-site review	Encounter data validation

Effective April 1, 2005, the Division of Medical Assistance contracted with MPRO to perform EQR activities for both the HMO and Piedmont program. (The HMO program was terminated effective August 1, 2006 and the EQR contract was amended to remove the HMO related activities.)

2. **Assurances For PAHP program.**

N/A The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one of more of these regulatory requirements for its PAHP program. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

___ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, and these contracts are effective for the period ____ to ____.

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.
N/A

a. ___ The State has developed a set of overall quality **improvement guidelines** for its PCCM program. Please attach.

b. ___ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

1.___ Provide education and informal mailings to beneficiaries and PCCMs;

2.___ Initiate telephone and/or mail inquiries and follow-up;

3.___ Request PCCM's response to identified problems;

4.___ Refer to program staff for further investigation;

5.___ Send warning letters to PCCMs;

6.___ Refer to State's medical staff for investigation;

7.___ Institute corrective action plans and follow-up;

8.___ Change an enrollee's PCCM;

9.___ Institute a restriction on the types of enrollees;

10.___ Further limit the number of assignments;

11.___ Ban new assignments;

12.___ Transfer some or all assignments to different PCCMs;

13.___ Suspend or terminate PCCM agreement;

14.___ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

c. ___ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

   A. ___ Initial credentialing

   B. ___ Performance measures, including those obtained through the following (check all that apply):

      ___ The utilization management system.
      ___ The complaint and appeals system.
      ___ Enrollee surveys.
      ___ Other (Please describe).

4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ___ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. __ Other (please describe).

d. ___ **Other quality standards** (please describe):

Section A: Program Description

Part IV: Program Operations

A. Marketing

Marketing includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

NOTE: Marketing activities are not applicable due to a sole source to one PIHP.

1. **Assurances**

___ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

_____ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

___ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities and these contracts are effective for the period ___ to ___.

2. **Details**

a. **Scope of Marketing**

1.___ The State does not permit direct or indirect MCO/PIHP/PAHP or PCCM marketing.

2.___ The State permits indirect MCO/PIHP/PAHP or PCCM marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

3.___ The State permits direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

b. **Description**. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1.___ The State prohibits or limits MCOs/PIHPs/PAHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

2.___ The State permits MCOs/PIHPs/PAHPs and PCCMs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3.___ The State requires MCO/PIHP/PAHP and PCCM to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

The State has chosen these languages because (check any that apply):

i.__ The languages comprise all prevalent languages in the MCO/PIHP/PAHP/PCCM service area. Please describe the methodology for determining prevalent languages.

ii.__ The languages comprise all languages in the MCO/PIHP/PAHP/PCCM service area spoken by approximately ___ percent or more of the population.

iii.__ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

X The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one of more of these regulatory requirements for PIHPs and PAHPs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements and these contracts are effective for the period April 1, 2005 to March 31, 2007 (with an option for a one year extension).

2. **Details.**

a. **Non-English Languages**

X Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain):

The State defines prevalent non-English languages as:
(check any that apply):

1.__ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."
2. **X** The languages spoken by approximately **5** percent or more of the potential enrollee/ enrollee population.
3.__ Other (please explain):

X Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.

Piedmont will make interpreter services available to individuals with limited English proficiency through contract with a telephone language line and will also contract with individual providers in the community for on-site interpretation. As a public MH/DD/SAS program, Piedmont is accustomed to making this service available to consumers on an as-needed basis.

X The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe**. (Please see the discussion below in item b regarding "enrollees" and "potential enrollees.")**

Under the wavier, the PIHP must inform the beneficiaries in writing of its policies before and at the time of enrollment. Through review of the results of Satisfaction Surveys, the State shall ensure that the enrollee orientation process for the waiver participants is conducted in a manner that is:

- **Respectful**
- **Understandable &**
- **Affords enrollees with necessary support through the process**

Piedmont has a 30 year history of public management of services for people with mental health, developmental disabilities, and substance abuse services in the Piedmont counties. This includes long standing relationships with public agency partners such as the school systems, departments of social services, health departments, and county government, as well as with local Advocacy organizations such as NAMI and the Arc's. Piedmont's Board consists of an elected County Commissioner from each county as well as other local citizens and stakeholders. Piedmont is the manager of local teams that include consumers/family members, providers and community agencies such as Interagency Teams, Child and Family Teams, Substance Abuse advisory boards and Collaboratives for Child Services across the counties. Piedmont has strong relationships with the courts, and law enforcement agencies as well. Piedmont has historically engaged stakeholders at the county level and is extremely knowledgeable of key resources, stakeholders and the nuances of each individual county. Piedmont also has a long standing relationship with state and regional agencies including State Psychiatric Hospitals, Mental Retardation Centers, Juvenile Justice and Criminal Justice Services. New strategies to expand and enhance these activities include the development of a Department of Community Relations and Office of Consumer Affairs.

The Community Relations Department is responsible for coordinating education and outreach across the Piedmont communities, that includes working with agencies that serve special needs clients, advocates for special needs populations, special needs beneficiaries and their families. This office centralizes community planning, education and outreach activities into one department of the LME in order ensure the array of staff specialties needed and for better coordination of activities across the five counties. This office includes a Licensed Adult Mental Health and Substance Abuse Professional, a Licensed Child Mental Health Specialist, an Hispanic Specialist, a Developmental Disabilities Specialist and a Housing

Coordinator. Responsibilities of this department include development of an annual community plan through county level Advisory Committees, community education, promotion of collaboration across agencies affecting the services for people with disabilities, and promotion of increased access to generic community resources for people with disabilities. The Hispanic specialist will focus on outreach to Hispanic populations in order to increase penetration.

Piedmont also has an office of Consumer Affairs, staffed by an openly declared consumer and will work to develop and identify consumer leaders, assist in community education, and will assist in outreach activities. The Director will serve as an ombudsman and advocate for individual cases and assist consumers as requested with appeals and grievances.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

X State

___ contractor (please specify) _____

___ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

The State considers <u>potential enrollees individuals who are eligible to receive services</u> from the PIHP, by virtue of the fact that they are enrolled in Medicaid in one of the five participating counties, <u>but are not accessing services</u>. <u>Enrollees are eligible individuals who are accessing/receiving services</u>.

The State intends to mail out written notices to all new Medicaid recipients in the catchment area. The notices will contain basic information regarding the provision of all mh/dd/sa services through the PIHP, the process for accessing services, including emergency services, and contact information including access sites and telephone numbers. In addition, the PIHP will conduct outreach as described above in B.2. to assure that Medicaid recipients who need and want services are able to receive them.

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

(i) ___ the State

(ii) ___ State contractor (please specify):_____
(ii) **X** the MCO/PIHP/PAHP/PCCM

The PIHP shall provide each new Enrollee who requests services, within fourteen (14) days of the request for services, written information on the Medicaid waiver program. Written information must be available in the prevalent non-English languages found in the Piedmont catchment area. All new Enrollee material must be approved by DMA prior to its release, and shall include information specified in the contract between DMA and the PIHP.

C. Enrollment and Disenrollment

1. **Assurances.**

X The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements and these contracts are effective for the period April 1, 2005 to March 31, 2007 (with an option for a one year extension).

2. **Details**. Please describe the State's enrollment process for MCOs/PIHPs/PAHP and PCCMs by checking the applicable items below.

a. **X** **Outreach.** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

- **The State will officially notify all potential enrollees by sending written communication to each Medicaid participant enrolled in Medicaid in one of the counties participating in the waiver.**
- **The State Medicaid agency will notify providers prior to program implementation through Medicaid Bulletins and a provider workshop.**
- **Consumers with questions on eligibility and enrollment will be directed to a toll free number for Piedmont's Access Unit. The Access unit will provide information and referral for benefits assessment as needed.**
- **Piedmont's Community Relations Department will coordinate education and outreach activities. This office plans for community education, including Access to Care, Appeals and Grievances, Consumer Rights, etc. As directed by consumers and stakeholders, information regarding access to the system will be widely available and in a**

variety of media. Media include advertising in print media, radio/television announcements, brochures, yellow pages, internet web sites and links to / from other sites, translation into other languages must occur to ensure that the information is widely available.

- **Piedmont will also have an Office of Consumer Affairs, directed by a primary consumer. This Office will also have wide participation in community forums in order to provide support for consumers and families during this transition.**

b. **Administration of Enrollment Process**.

X State staff conducts the enrollment process.

Since this waiver program will be sole-sourced to the Piedmont PIHP, the State will use its Medicaid Eligibility Information System (EIS) to identify and enroll persons covered by the waiver.

___ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

___ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: _____

Please list the functions that the contractor will perform:

___ choice counseling
___ enrollment
___ other (please describe):

___ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

c. **Enrollment.** The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

X This is a **new** program. Please describe the **implementation schedule** (e.g. implemented Statewide all at once; phased in by area; phased in by population, etc.):

The program was implemented across the five-county area for all eligibility categories listed in the waiver application on April 1, 2005.

___ This is an existing program that will be **expanded** during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented Statewide all at once; phased in by area; phased in by population, etc.):

___ If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

N/A

i. ___ Potential enrollees will have____days/month(s) to choose a plan.

ii. ___ Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

X The State **automatically enrolls** beneficiaries

___ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)

X on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)

___ on a voluntary basis into a single MCO, PIHP, or PAHP, and beneficiaries can opt out at any time. Please specify geographic areas where this occurs: _____

___ The State provides **guaranteed eligibility** of ____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

___ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:
The State does not exempt any enrollees from enrolling in the Plan. All Medicaid MH/DD/SA services will be provided through the single PIHP to Medicaid enrollees in the five-county area.

___ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

d. **Disenrollment:**

___ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the

first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

i.___ Enrollee submits request to State.

ii.___Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

iii.___Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

X The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

N/A The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of ____ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c). Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

N/A The State **does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

___ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees. Please check items below that apply:

i.___ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:

ii.___ The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

iii.___ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.

iv.___ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

D. Enrollee rights.

1. **Assurances.**

X The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

_____ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections, and these contracts are effective for the period April 1, 2005 to March 31, 2007 (with an option for a one year extension.

X The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

E. Grievance System

1. **Assurances for All Programs**. States, MCOs, PIHPs, PAHPs, and States in PCCM programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

X The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

___ Please describe any special processes that the State has for persons with special needs.

2. **Assurances For MCO or PIHP programs**. MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

X The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHPs. Please identify each regulatory requirement waived and the State's alternative requirement.

_X__ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, and these contracts are effective for the period April 1, 2005 to March 31, 2007 (with an option for a one year extension).

3. **Details for MCO or PIHP programs**.

a. **Direct access to fair hearing**.

X The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a State fair hearing.

___ The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a State fair hearing.

b. **Timeframes**

X The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is **30** days (between 20 and 90).

X The State's timeframe within which an enrollee must file a **grievance** is **30** days (may not exceed 90).

N/A 4. **Optional grievance systems for PCCM and PAHP programs**. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

___ The State has a grievance procedure for its ___ PCCM and/or ___ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

___ The grievance procedures is operated by:
- ___ the State
- ___ the State's contractor. Please identify: _____
- ___ the PCCM
- ___ the PAHP.

___ Please provide definitions the State employs for the PCCM and/or PAHP grievance system (e.g. grievance, appeals)

___ Has a grievance committee or staff who review and resolve grievances. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

___ Reviews requests for reconsideration of initial decisions not to provide or pay for a service.

___ Specifies a time frame from the date of action for the enrollee to file a grievance, which is: _____

___ Has time frames for staff to resolve grievances for PCCM/PAHP grievances. Specify the time period set: _____

___ Establishes and maintains an expedited grievance review process for the following reasons:_____ . Specify the time frame set by the State for this process____

___ Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the grievance.

___ Notifies the enrollee in writing of the grievance decision and further opportunities for appeal, as well as the procedures available to challenge or appeal the decision.

___ Other (please explain):

F. Program Integrity

1. **Assurances.**

X The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;

(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

X The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3) Employs or contracts directly or indirectly with an individual or entity that is
   a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   b. could be excluded under 1128(b)(8) as being controlled by a sanctioned individual.

2. **Assurances For MCO or PIHP programs**

X The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

X State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604

Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for MCOs or PIHPs. Please identify each regulatory requirement waived and the State's alternative requirement.

_X__ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. These contracts are effective for the period April 1, 2005 to March 31, 2007 (with an option for a one year extension).

Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, States must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, States must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP Capacity, Specialty Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality Assessment and Performance Improvement, PCCM Quality)

For each of the programs authorized under this waiver, this Part identifies how the State will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring strategy may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the strategies used to monitor the major areas of the waiver. The second is a detailed description of each strategy.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the State and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The State must have a quality strategy in which certain monitoring strategies are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring strategies they deem most appropriate for their programs.

For MCO and PIHP programs, a State must check the applicable monitoring strategies in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the State may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the State to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality

strategy for PAHP programs. However, States must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under "Program Impact." However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring strategies to use.

I. Summary chart

States should use the chart on the next page to summarize the strategies used to monitor major areas of the waiver program. If this waiver authorizes multiple programs, the State may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the State should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

Strategy	Program Impact						Access			Quality		
	Choice	Marketing	Enroll Disenroll	Program .Integrity	Information	Grievance	Timely Access	PCP/Specialist Capacity	Coordination Continuity	Coverage Authorization	Provider Selection	Quality of Care
Accreditation for Deeming												
Accreditation for Participation												
Consumer Self-Report data	**X**				**X**	**X**	**X**				**X**	**X**
Data Analysis (non-claims)			**X**			**X**	**X**	**X**		**X**		**X**
Enrollee Hotlines	**X**		**X**		**X**	**X**	**X**		**X**	**X**	**X**	**X**
Focused Studies												
Geographic mapping	**X**							**X**			**X**	
Independent Assessment	**X**			**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Measure any Disparities by Racial or Ethnic Groups			**X**									
Network Adequacy Assurance by	**X**		**X**					**X**			**X**	

Strategy	Program Impact						Access			Quality		
	Choice	Marketing	Enroll Disenroll	Program .Integrity	Information	Grievance	Timely Access	PCP/Specialist Capacity	Coordination Continuity	Coverage Authorization	Provider Selection	Quality of Care
Plan												
Ombudsman												
On-Site Review	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Performance Improvement Projects				**X**								**X**
Performance Measures			**X**			**X**	**X**	**X**	**X**	**X**		**X**
Periodic Comparison of # of Providers	**X**							**X**			**X**	
Profile Utilization by Provider Caseload												
Provider Self-Report Data					**X**							
Test 24/7 PCP Availability												
Utilization Review			**X**				**X**					**X**
Other: (describe)												

II. Monitoring Strategies

Please check each of the monitoring strategies or functions below used by the State. A number of common strategies are listed below, but the State should identify any others it uses. If federal regulations require a given strategy, this is indicated just after the name of the strategy. If the State does not use a required strategy, it must explain why.

For each strategy, the State must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. State Medicaid, other State agency, delegated to plan, EQR, other contractor)
- Detailed description of strategy
- Frequency of use
- How it yields information about the area(s) being monitored

a. ____ Accreditation for Deeming (i.e. the State deems compliance with certain access, structure/operation, or quality requirements for entities that are accredited)

___ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

b. _____ Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

___ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

c. **X** Consumer Self-Report data

___ **CAHPS** (please identify which one(s))
X State-~~developed~~ approved survey
___ Disenrollment survey
___ Consumer/beneficiary focus groups

The PIHP will be required by contract to complete an annual survey or other standardized consumer satisfaction survey approved by the Division for adults and children as part of the statistical reporting requirements contained in the contract. The survey will measure consumer perception of the PHIP's performance in the areas of access and timeliness of services and quality of care.

d. **X** Data Analysis (non-claims)

X Denials of referral requests

The PIHP will report to the Division annually the number and percentage of visits for services (ER, consulting specialists, ancillary) obtained but not authorized by the PIHP. The PIHP maintains Grievance Procedures as described in Appendix VII of the contract, which include timely written notification of referral denials to the enrollee and appeal rights. The PIHP maintains a record of encounters on the telephone access line to include the date of the call, type of the call, and disposition. . The PIHP will monitor Access Call Center telephone activities, and will develop and implement corrective action plans as necessary. The Division, by contract, shall have the right to review this data and any trends that may require the PIHP to implement a corrective action plan.

_ __ Disenrollment requests by enrollee
_ __ From plan
__ _ From PCP within plan
X Grievances and appeals data
___ PCP termination rates and reasons
___ Other (please describe)

The PIHP will maintain records of grievances and appeals within its internal global Continuous Quality Improvement (CQI) program. The PIHP will also submit quarterly reports to the Division on the number, type and resolution of complaints, grievances, and appeals. The PIHP will review these reports to identify potential areas of concern in plan performance and will develop corrective action plans as needed. The Division will monitor this data for any trends that may require the PIHP to implement a corrective action plan. Any plans of correction proposed by the PIHP must be approved by DMA prior to implementation and will be monitored by DMA. There is no option for disenrollment from the PIHP.

e. X Enrollee Hotlines operated by State **and the PIHP**
Both DMA and the Department of Health and Human Services (DHHS) operate customer hotlines during business hours to address recipient coverage questions and requests for assistance. Concerns or issues that cannot be handled by the hotline staff are referred to the appropriate program or person within DMA. The PIHP operates a customer service line 24/7 to address enrollee needs and concerns.

f. _____ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

g. **X** Geographic mapping of provider network

The PIHP will maintain geographic mapping of the provider network for the Division's review during site visits.

h**. X** Independent Assessment of program impact, access, quality, and cost-effectiveness
The State will arrange for an Independent Assessment as required by CMS.

i**. X** Measurement of any disparities by racial or ethnic groups **The PIHP will include items on the annual consumer satisfaction survey to assess cultural sensitivity.**

j. **X** Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

Per Section 6.4 Accessibility of Services of the Contract, the PIHP is required to establish and maintain appropriate provider networks. Additional contract mandates require the PIHP to establish policies and procedures to monitor the adequacy, accessibility, and availability of its provider network to meet the needs of Enrollees. The PIHP shall conduct an analysis of its provider network to demonstrate an appropriate number, mix, and geographic distribution of providers, including geographic access of its memberships to practitioners and facilities. The analysis will be reviewed by the Division at the beginning of the contract; at any time there has been a significant change in the PIHP's operations that would affect adequate capacity and services, including changes in services, benefits, geographic service areas or payments or enrollment of a new population in the PIHP; and annually thereafter during annual site visits. Whenever network gaps are noted, the PIHP shall submit to the Division a network development strategy or plan as well as reports to the Division on the implementation of the plan or strategy.

k. _____ Ombudsman

l. **X** On-site review

The Division of Medical Assistance and the Division of Mental Health/Developmental Disabilities/Substance Abuse Services will conduct annual on-site reviews to evaluate compliance with the terms of the Contract, compliance with State and Federal Medicaid requirements, the PIHP's compliance with NC G.S. 122C-112.1, and implementation of the PIHP's local business plan. The review will consist of both interviews and documentation review. Any compliance issues found on review will require the submission of a corrective action plan. The DMA, the Division of Mental Health Developmental Disabilities and Substance Abuse Services, (DMH/DD/SAS), and the Intra-Departmental Monitoring Team (IMT) will approve and monitor any corrective action plan.

The frequency of on-site reviews may be decreased to every two years at the discretion of DMA if DMA determines that other required on-site review activities such as the EQRO and Independent Assessment are sufficient to assure the effective operation of the PIHP and compliance with State and Federal requirements.

m. **X** Performance Improvement projects [**Required** for MCO/PIHP]
- **X** Clinical
- **X** Non-clinical

In the Contract, Attachment O describes the performance improvement projects required for each contract year. The first year of the Contract, the PIHP will plan and implement one non-clinical and one clinical performance improvement project. The non-clinical project for the first year will be "Improving resolution of complaints within established guidelines", and the clinical topic will be "Improving coordination of care and reducing recidivism rates in State facilities." During year two of the Contract, the PIHP must plan and implement an additional performance improvement project for a total of three. For year three of the Contract, the PIHP must plan and implement an additional performance improvement project for a total of four. The project topics will be determined jointly by the Division and the PIHP from the clinical and non-clinical focus areas listed in Appendix VI of the contract. Baselines will be established the first year of each project and the PIHP will set benchmarks for each project based on currently accepted standards, past performance data, or available national data. Full documentation to include the project title, planning and evaluation, supporting data and interventions will be reported to the Division no later than July 31st of each contract year.

n**. X** Performance measures [**Required** for MCO/PIHP]
- Process
- Health status/outcomes
- Access/availability of care
- Use of services/utilization
- Health plan stability/financial/cost of care
- Health plan/provider characteristics
- Beneficiary characteristics

The Division and the PIHP will determine jointly the focus areas for all performance measures. The topics listed above are included in the Contract as choices for focus areas and are listed in Attachment N of the Contract.

o**. X** Periodic comparison of number and types of Medicaid providers before and after waiver

The Division will compare the PIHP provider network numbers and types on an annual basis using results from the PIHP reported Network Capacity measure as required in Appendix V of the Contract.

p. ____ Profile utilization by provider caseload (looking for outliers)

q. **X** Provider Self-report data

X Survey of providers

___ Focus groups

Included in the annual statistical reporting, the PIHP must conduct an annual Provider Satisfaction Survey to include the provider's self-reported satisfaction with the PIHP's performance in the areas of claims submissions, timeliness of payments, assistance from PIHP and communication with the PIHP. The survey will be developed by the PIHP and approved for use by the Division. The survey will be reported to the Division annually as required in Appendix V of the contract.

r. _____ Test 24 hours/7 days a week PCP availability

s**. X** Utilization review (e.g. ER, non-authorized specialist requests)

The PIHP will monitor utilization through its global CQI committee by reviewing data reports on utilization as well as monitoring enrollee calls coming into the service center. The Division requires annual statistical reporting of utilization measures listed in Attachment N of the Contract to include the following: Mental Health Utilization-Inpatient Discharges and Length of Stay; Percentage of Members Receiving Inpatient, Day/Night Care, Ambulatory and Other Support Services; Chemical Dependency Utilization-Inpatient Discharges and Average Length of Stay; Chemical Dependency Utilization-Percentage of Members receiving Inpatient, Day/Night Care, Ambulatory and Support Services, Identification of Alcohol and Other Drug Services; and Utilization Management of the Provision of High Use Services. Each of these measures is described in Attachment N of the contract. The reports will be due no later than June 30th of each contract year. The PIHP will use all applicable HEDIS technical specifications pertaining to the Medicaid population. The measurement year will be January 1st-December 31st of each contract year with the exception of year one of the contract. The PIHP was operational April 1, 2005; the PIHP was required to report on a subset of measures by July 31, 2005 covering the period April 1, 2005 through June 30, 2005. By June 30, 2006, the PIHP was required to report on the first nine months of PIHP operation covering the period April 1, 2005 through December 31, 2005. Thereafter, all measures will be required for reporting on a calendar year basis by June 30th following the end of the calendar year.

t. Other: (please describe)

Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

___ This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

X This is a renewal request.

___ This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.

X The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

Please replicate the template below for each activity identified in Section B:

(c.) Strategy - Consumer Self-Report Data

The PIHP conducted a baseline consumer satisfaction survey April – December 2005 to measure overall satisfaction with services by the PIHP network of providers. The survey was conducted by MarketWise by mail with 10,000 surveys mailed out and a total of 618 completed questionnaires (6.2%) were returned. More than half of the consumers (54%) have received services from the PIHP network of providers for more than two years.

Confirmation it was conducted as described:

X Yes

___ No. Please explain:

Summary of results:

Consumer Service Attributes:

- **84% of the total consumers indicate they are satisfied or extremely satisfied with the services provided by the PIHP network of providers.**
- **86% of consumers indicate their service plan meets their needs, or meets their needs most of the time.**
- **84% of consumers also participate in the planning of their services.**
- **86% of consumers indicate the services that are available definitely meet their needs or meet them most of the time.**
- **81% of consumers believe that over the past year the services they have received have definitely improved the quality of their life or have improved it most of the time.**

The service attributes that are rated with the highest satisfaction are: respecting privacy with 96% rating definitely or most of the time, and ability to meet the needs of consumers' racial/ethnic background with 93% rating definitely or most of the time.

The service attributes rated lowest: ease of being able to change provider, with 70% of consumers rating definitely easy or easy most of the time. Also, 73% of consumers indicate they definitely have a choice in selecting a provider most of the time.

Network Staff-related Attributes:

- **90% of consumers indicate the staff is definitely able to address the needs of the consumer's racial and ethnic community.**
- **81% indicate that the quality of service when staff changes definitely remains the same most of the time.**
- **83% indicate the staff is definitely available when needed or most of the time.**

Consumer Appointment Attributes:

- **88% indicate that appointment times are definitely available when needed or most of the time.**
- **89% indicate if they have scheduled an outpatient appointment, they definitely see the provider within one hour or they do so most of the time.**
- **75% of consumers in the survey indicate that treatment options have been explained, service locations are convenient, a handbook was received within 14 days of enrollment, and they are aware of their rights and responsibilities as a network consumer.**

Consumer attributes with the lowest ratings: only 66% indicate the denial and appeal process has been explained to them; and less than half of the consumers (44%) indicate they know the PIHP call center toll-free number.

Problems identified:

- **Choice of provider and ease in changing providers**
- **Lack of explanation of the denial/appeal process**
- **Consumer awareness of the PIHP toll-free number**

Corrective action (plan/provider level):

- **Choice/change of providers: The survey indicated that difficulty in changing or choosing providers was a problem experienced primarily by consumers of substance abuse services rather than consumers of mental health and DD services. The PIHP hired an additional network staff person to focus on improving access to substance abuse services providers.**
- **Toll Free Access Number: After obtaining the results of the survey, the Piedmont PIHP determined that the toll free number (800-939-5911) had been advertised primarily as a crisis number ("Don't call 911 – call 5911 instead"). The PIHP reprinted and distributed its brochure, hand-outs, newspaper advertisement and a refrigerator magnet with emphasis on the toll free number as an access number for information, assessment, referrals, etc., as well as crisis care.**
- **Denial/Appeal Process: The PIHP developed and distributed a brochure explaining denials/terminations and appeal rights under Medicaid and provided toll-free numbers for legal assistance. Piedmont also updated the consumer and family handbook with a section dedicated to denials/terminations and appeal rights specifically for Medicaid recipients.**

Program change (system-wide level): N/A

(d.) Strategy - Data Analysis: The PIHP tracks and reports to DMA on unauthorized visits/claims denials, complaints, and denials/appeals of service requests.

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results:

- **The PIHP reports the number and percentage of claims denied annually. The percentage of denied claims during the first calendar year of operation (4/1/05 though 12/31/05) was approximately 9%. There was an increase in the denial rate during the last two months of the year due to the PIHP adhering more stringently to the requirement for providers to obtain prior authorization before providing services.**
- **DMA requires quarterly and annual reports on complaints and grievances. The reports address type of complaint (administrative, access or quality/service provision); source of complaint (provider, consumer/family or stakeholder); type of provider (DD, MH or SA); and resolution of complaint. There were a total of 85 complaints during the first calendar year which consisted of nine months of operation (4/1/05-12/31/05). There were a total of 120 complaints during the most recent analysis over a six-month period (January-June 1006). Complaints resolved within the 30-day timeframe increased from 41% to 60% from the first reporting period to the next. Except for the increase in the number of complaints and the decrease in resolution time, other variables have remained about the same across the two reporting periods. Most complaints tend to be about quality/service provision; most come from the consumer/consumer's family; and the type of provider most complained about tend to be providers of mental health services.**
- **Quarterly reports on number, types and disposition of appeals are also submitted. During the first six quarters of operation (April 2005-September 2006), the number of appeals ranged from five to 40 with the median being nine. A minimum of five were overturned.***

Problems identified:

- **Increase in the number of complaints: This was partly due to the change in the State's MH/DD/SAS service package, the divestiture of case management services by the PIHP, and the short timeframe for implementing these changes. This was a challenge statewide and not specific to this waiver. The increase is also due to staff education and training within the various departments of the PIHP on handling and tracking complaints.**
- **Insufficient detail about complaints is being provided to determine trends, identify problems with specific providers, operational issues or policies/procedures that are not working well, etc.**
- **Timeframe for resolving complaints exceeds the 30-day limit.**
- **Unable to determine the number of appeals upheld/overturned due to pending status at time of quarterly reporting**

Corrective action FOR COMPLAINTS (plan/provider level): The following actions are being taken by the PIHP:

- **The PIHP revised its complaint policy and procedure.**
- **Complaint intake and tracking were centralized.**
- **Required training sessions on complaint policy and procedure were provided to staff in all departments.**
- **Consumer involvement with the complaint process was increased through the CFAC and Client's Rights Committee.**
- **The complaint database has been revised to incorporate additional data fields for reporting to the state. DMA is currently working with Piedmont to redesign reporting.**

As a result of these interventions, the following trends are predicted:

- **The number of complaints should continue to increase for the coming year because staff will more accurately identify what constitutes a complaint**
- **The resolution time should continue to decrease**
- **The number of complaints resolved within 30 days should increase for the coming year**

Corrective action FOR APPEALS (plan/provider level):
The current report does not provide follow-up on appeals that were pending at the end of each quarter so the State is unable to capture accurate data on how many actions were overturned or upheld. The State and the PIHP are working together to revise reporting in this area.

Program change (system-wide level):
Change in report elements as described above.

(e.) Strategy - Enrollee Hotlines: Both the State and the Plan have hotlines/toll free numbers for consumer complaints, concerns, information and referral.

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: **Although DMA has a managed care/customer service hotline available, consumers tend to use the PIHP hotline and issues are resolved at the PIHP level. Both quarterly and annual reports are provided to DMA by the PIHP on numbers and types of calls and response times. The PIHP operates its own hotline and contracts with a vendor for back-up. Response times have remained consistent and the PIHP's staff-operated line tends to both respond more quickly and have longer conversations with callers. Over the past calendar year (4/1/05-12/31/05), the PIHP's average answer time was 8 seconds while the vendor's was 13 seconds; the PIHP's average abandonment rate was .2% while the vendor's was 3.6%. The average length of call for PIHP staff was 7.5 minutes and the vendor's was 4.3 minutes. Call center reports show that the ACCESS line answered a large majority of calls (87%) within thirty seconds, and there was a very low call abandonment rate (3.6%). A large number of calls from providers requesting referrals resulted in an increased volume of calls rolling over to a subcontracted backup call center.**

Problems identified:
The large volume of calls from providers requesting referrals was consuming a large majority of ACCESS line availability and staff's time, and many calls had to roll-over to a back-up call center. Barriers were also identified in capturing referrals data and in ability to make referrals to independent practitioners.

Corrective action (plan/provider level):
A designated separate telephone line for providers to call to make referrals has decreased the number of calls that roll-over to the back-up call center from 1,500 per month to 400 per month. Other improvement efforts have included training call center staff in call tracking and staff communication, and providers were requested to submit a report of when referrals are scheduled.

Program change (system-wide level): **N/A**

(g.) Strategy - Geographic Mapping: **Geo-mapping of the five-county catchment area has been done by the Plan and has been reviewed at every site visit since the waiver's inception. The map is maintained by the Plan and kept up to date by the Network department. The Plan has ordered software that will allow mapping of services and provider by zip code. It is anticipated that the switch to electronic data collection for reporting will be made in 2007. The Plan has also completed a network adequacy study by region to help identify any unmet service needs.**

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: **Location of providers within the five county area meets the 30 minute/ 30 mile rule under the waiver (45 minutes/45 miles in rural areas). The Plan has been able to identify that consumers travel to contiguous counties for many outpatient services and has enrolled a number of Licensed Independent Practitioners in those counties to increase consumer choice.**

Problems identified:

- **The Plan needs more contracts with community hospitals within the five county area in order to support family involvement and treatment in the home and community. The Plan currently relies heavily on State facilities for inpatient treatment.**
- **The need was identified for the new Medicaid community- based services such as Multi-Systemic Therapy, Intensive In-Home, Community Supports, and Community Support Team, to decrease reliance on residential treatment for children/adolescents and hospitalization for adults.**
- **Since the waiver program went into effect, the Plan has developed Crisis and Detox services within the five county catchment area as an alternative to being seen at an emergency room. Further development of a crisis services continuum for adults and children/adolescents, including Mobile Crisis services, is needed.**
- **Additional residential resources for TBI consumers in the Piedmont catchment area are needed. The State currently has only one TBI resource.**

Corrective action (plan/provider level):
Provider network development as described above is a component of the PIHP's goals and work plan for state fiscal year 2006-2007 (7/1/06 through 6/30/07). Progress to date includes:

- **Piedmont Behavioral Healthcare (PBH) actively recruited providers for the new community based services and developed pilot programs before the March 2006 statewide implementation of these new services. Specific reporting has been required through the Plan-Provider contracts, and a steering committee to obtain feedback on the implementation of these new services is in place. There is ongoing discussion related to opportunities for improvement and improved penetration.**
- **Regarding Crisis and Detox services, the project plan for children and adolescents has a stakeholders workgroup which is co-facilitated by a Consumer and Family Advisory Committee (CFAC) member who is committed to the System of Care. PBH has also recognized the need for a comprehensive plan of implementation for these services which will involve education and outreach at many levels prior to new service implementation**
- **The DD Provider Relations Manager has taken a leadership role to begin the discussions on increasing TBI resources.**

Program change (system-wide level): Home and community based services and person centered planning are key components of the State's MH/DD/SAS reform effort. Thus, the Plan's focus on the services and providers described above is in line with the statewide transition.

(h.) Strategy - Independent Assessment: The State will conduct an independent assessment of impact, access, quality and cost-effectiveness as required by CMS.

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: The State awarded a contract effective June 16, 2006 to Navigant Consulting for an Independent Assessment of the PIHP as required by CMS. Navigant is in the process of gathering and reviewing information, gathering stakeholder feedback, summarizing findings of qualitative data analysis, and evaluating pre and post-waiver access, quality, and cost effectiveness. Navigant's final

Independent Assessment report is expected no later than June 1 of 2007. (The deadline for submission was extended to 60 days from the renewal date in previous discussions with CMS.)

Problems identified: N/A

Corrective action (plan/provider level): N/A

Program change (system-wide level): N/A

(i.) Strategy - Measure Disparities by Racial/Ethnic Group

Confirmation it was conducted as described:

X Yes
___ No Please explain:

Summary of results: Two of the items in the consumer satisfaction survey referenced in item (c.) above addressed cultural sensitivity. Ninety-three percent of respondents said that providers met their needs related to race/ethnicity definitely or most of the time; ninety per cent responded that staff was able to meet the needs of the consumer's racial/ethnic community.

Problems identified: Survey comments indicate that additional choices as to race/ethnicity need to be included on the survey (particularly mid-eastern and bi-racial categories). In addition, the survey was not translated into Spanish. (Approximately 3.5 % of NC Medicaid recipients report that their language preference is Spanish.) There was also some concern expressed about the availability of interpreter services.

Corrective action (plan/provider level): The Plan is translating the survey into Spanish for future use and is also adding more race/ethnicity choices. The Plan needs to make sure enrollees are aware that interpreter services are available.

Program change (system-wide level): N/A

(j.) Strategy - Network Adequacy: Addressed in item g above

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: See item g.

Problems identified: See item g.

Corrective action (plan/provider level): See item g.

Program change (system-wide level): **See item g.**

(l.) Strategy - On-Site Review: The Division of Medical Assistance and the Division of Mental Health/Developmental Disabilities/Substance Abuse Services conducts annual on-site reviews to evaluate compliance with the terms of the Contract, compliance with State and Federal Medicaid requirements, the PIHP's compliance with NC G.S. 122C-112.1, and implementation of the PIHP's local business plan. The review consists of both interviews and documentation review. Any compliance issues found on review will require the submission of a corrective action plan. The Division and the Division of Mental Health/Developmental Disabilities/Substance Abuse Services will approve and monitor any corrective action plan.

Confirmation it was conducted as described:

X Yes

___ No. Please explain:

Summary of results: The review was conducted on April 12-13 by staff from DMA and DMH/DD/SAS with assistance from Mercer Government Human Services Consulting. The team reviewed overall PIHP operations, including utilization and care management, clinical direction, executive management, claims processing, financial management, information systems and reporting. A written report of findings was completed and reviewed with the PIHP and a plan of correction for deficiencies was developed. Progress with the plan of correction is tracked by the Division of Medical Assistance, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the Piedmont Intra-Departmental Monitoring Team.

Overall, findings from the review suggest that Piedmont Behavioral Healthcare (PBH) has implemented the Plan successfully. Yet, there were significant challenges to operations of the behavioral health capitated program. Multiple strengths were noted in PBH's operations. The highlights are summarized below:

- **PBH hired senior clinical staff with expertise in child/adolescent services to provide supervision and support to the care management/utilization management process.**
- **Clinical operations – intake, care management, utilization management – are well organized and demonstrate responsiveness to members' needs (despite being understaffed due to vacancies and low staff-to-member ratios).**
- **PBH hired a new director of Quality Management (QM) who organized the department and worked collaboratively and effectively to increase efficiency and reduce overlap with Network Operations. PBH is in the planning phase of applying for accreditation by the NCQA, the primary accreditation body for managed care organizations. A Global CQI committee was established.**
  Network Operations streamlined functions by addressing overlap in roles and responsibilities with Human Resources staff and QM. The Network team emphasizes identification of service gaps and contracting for services that exemplify best practices. The team embraces its role to expand the continuum of services available to members. Multiple venues are in place to encourage provider participation: a Network Council with elected representatives and officers; regular network meetings; and collaboration with six area hospitals and state psychiatric facilities on crisis planning.
- **PBH established a Consumer and Family Advisory Committee and has consumer representation on major committees (Network Council, Global CQI Committee).**

- **PBH's leadership successfully expanded the scope and type of services available to its members (e.g., crisis services for discrete populations), issuing requests for proposals for new services that offer appropriate alternatives to more intensive and costly treatment. A Housing Continuum of Care Plan was developed and PBH obtained a HUD housing grant. PBH also obtained a primary care collaboration grant that enables more collaboration with primary care providers. Further, PBH initiated a Cultural Competency Workgroup, developed a Cultural Competency Plan, and is in the process of implementing the plan.**
- **PBH identified information system needs, initiated a design and implemented a new system.**

These strengths are noteworthy. Yet, PBH faced several significant challenges during its first year of operation, as follows:

- **The Information System (IS) purchased by PBH did not provide the scope of managed care functions desired, such as effective claims management and reporting. Also, it did not provide the right amount of clinical data for use in managing care and promoting efficient use of resources. As a result, PBH began building its own IS, a time-consuming and complex process that was still underway at the time the report was conducted.**
- **A statewide change in service definitions (the State's MH/DD/SAS system reform) occurred in March 2006 that impacted many aspects of PBH's operations:**
  - **member notifications of service changes and options;**
  - **implementation of the new State service definitions;**
  - **endorsement of all providers in the network to ensure capability of being able to deliver new State service definitions.**
  - **provider network communications and modifications of network management protocols and upcoming contracts;**
  - **care management and utilization management policy and protocol revisions;**
  - **IS changes to accommodate new definitions; and,**
  - **claims system changes.**
  - **CMS required PBH to disband its targeted case management program consistent with changes in the State Plan, which increased the responsibilities of its ACCESS/care management staff (for the MH/SA consumer population), while placing additional demands on the information system to support clinical operations at the care management level.**

<u>Problems identified:</u>

Six major areas warrant attention and required plans of correction:

- **Intake/Care Management/Utilization Management**
- **Quality Management**
- **Information System**
- **Claims Management**
- **Reporting**
- **Financial Management**

1. **<u>Intake, Care Management, and Utilization Management:</u> The intake, care management, and utilization management functions are inadequately staffed. The loss of the targeted case management function at PBH further intensifies the gap in clinical care management resources. The care management/utilization management function is the cornerstone of a**

managed care program. Limited staffing has resulted in delays in implementing policies and procedures, inability to "blind" monitor calls, and review inter-rater reliability (IRR) of the call answering and care management processes. It is also important to have consistent approaches to authorization of care for the developmental disabilities program as well as for mental health and substance abuse services. Implementation of a fully functional IS to capture data through the intake, care management and utilization management processes is critical for these staff to manage care effectively.

2. **Quality Management: The quality management function at PBH focuses primarily on provider quality and compliance. At this time, QM of the internal clinical operations is not a focus. QM may be overstaffed, especially in comparison to the intake, care management, and utilization management functions. This appears to have occurred due, in part, to the limited availability of reports that are critical to managed care operations. Use of management reports would allow QM to focus on high volume and problem providers by reviewing outcomes and exceptions. Instead of a data driven approach, the QM function focuses on more process oriented activities such as annual provider on-site reviews and chart audits. A combination of outcome and process approaches to QM is necessary for both internal operations and the provider network. The IMT/Mercer Team recognizes that PBH has the responsibility to monitor all residential services, including those funded and/or licensed by the State and not enrolled in PBH's network. Despite this requirement, QM appears to be overstaffed. Thus, we recommend reevaluating the QM function and assessing the feasibility of transferring some QM clinical staff to care management.**

3. **Information System: The availability of an IS system that can provide data to manage is critical to operations. PBH is implementing a new IS to improve its capabilities to manage eligibility, claims, clinical and administrative operations, and reporting. The new system is under development by an external contractor (a former employee). PBH will need to build internal capacity to manage and use the IS effectively. Systems project management will be critical for improvements in the IS and for ongoing maintenance and updates. To avoid reliance on data collected manually, point in time information or independent information not integrated with other data should be available. It is critical to have the IS operational. Executive management and mid-level managers must have access to real time data and ongoing reports to make management decisions.**

4. **Claims Management: Policies and Procedures (P&Ps) for claims processing require updating.**

5. **Reporting: The availability of routine reports to monitor financial and clinical operations is minimal. Many reports are ad-hoc. Reports that could assist with clinical management and/or financial efficiencies are either not developed or not run. Further, PBH's reports to the State contain inconsistencies in the reported data, such as the balance reported as "incurred by not reported claims liability." The availability of correct and consistent reporting is a key managed care tool and necessary to protect its ongoing financial health and clinical integrity.**

6. **Financial Management: The absence of a Risk Management Plan is a crucial area that should be addressed as soon as possible. The Risk Management Plan typically identifies financial and/or utilization trends that could impact the financial operations of the plan.**

Corrective action (plan/provider level): **DMA and DMH/DD/SAS staff and the Plan have worked closely together to implement a detailed plan of correction. The plan of correction focuses on stabilization, growth and improvement of the IS and the transition to a data driven style of management. Progress is reported at the quarterly IMT meetings. A summary of some of the key activities underway by the Plan is provided below:**

- **The Plan has hired an additional UM staff person with managed care background.**
- **Retrospective and concurrent reviews of UM decisions have been implemented.**
- **Live call monitoring has been implemented.**
- **HEDIS reporting is now being used to support UM.**
- **Principles of recovery and resiliency have been included in practice guidelines as recommended by reviewers.**
- **The Plan is reviewing overall staffing with target date for completion of a staffing plan in February 2007.**
- **A provider performance plan is being implemented.**
- **Two additional IS staff have been hired.**
- **Risk management plan is being developed.**

In addition, DMA has arranged to provide technical assistance to the Plan starting in January in the areas of claims processing, risk management, and report design.

Program change (system-wide level): N/A

(m) Strategy - Performance Improvement Projects: In the first year of the contract, the PIHP developed and implemented one clinical and one non-clinical performance improvement project. The clinical project study topic is Improving Coordination of Care and Reducing Recidivism Rates in State Facilities and the non-clinical study topic is Improving Resolution of Complaints Within Established Guidelines. The EQRO (MPRO) completed validation of these two Performance Improvement Projects.

Confirmation it was conducted as described:

Yes Yes
___ No. Please explain:

Summary of results: The 2006 EQR Performance Improvement Project Validation Report findings were as follows:

- **Improving Resolution of Complaints Within Established Guidelines (non-clinical study) – Confidence in reported MCO PIP results**
- **Improving Coordination of Care and Reducing Recidivism Rates in State Facilities (clinical study) – Low confidence in reported MCO PIP results**

The PIHP submitted a plan for corrective action for all of the recommendations to the EQRO (MPRO) by 10/31/06.

Problems identified: EQR recommendations were for the information described in both PIPs to be transferred into a final narrative report and for the addition of baseline data and literature reviews to the

clinical study, and also for date ranges to be added and placed in chronological order for the study interventions.

Corrective action (plan/provider level): The PIHP submitted a corrective action plan (CAP) for the above recommendations made by MPRO for the Validation of Performance Improvement Projects. The EQRO (MPRO) reviewed this CAP and found the PIP Validation to be subsequently fully compliant, and amended the 2006 PIP Validation report to show full compliance.

Program change (system-wide level): N/A

(n) Strategy - Performance Measures: By June 30, 2006 the PIHP reported all Statistical Reporting Measures (Attachment N of the risk contract) due annually for the first nine months of operation for the number of months for which the capitated Medicaid payments are paid (April 1, 2005 through December 31, 2005). The Complaints/Grievance/Appeals measure was reported initially after the first calendar quarter of Plan operations and quarterly thereafter.

The following seven Performance Measures were validated by the EQRO (MPRO):

- **Follow-up after Hospitalization for Mental Illness (HEDIS measure)**
- **Mental Health Utilization (HEDIS) measure**
- **Chemical Dependency Utilization (HEDIS measure)**
- **Number of Consumers moved from Institutional Care to Community Care (C-waiver)**
- **Initiation and Engagement of Alcohol and other Drug Dependence Treatment (HEDIS)**
- **Utilization Management of the Provision of High Use Services (C-waiver)**
- **Complaints/Grievances/Appeals**

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: The 2006 EQR Performance Measurement Validation Report findings were as follows:

- **Follow-up after Hospitalization for Mental Illness – Substantially Compliant**
- **Mental Health Utilization – Fully Compliant**
- **Chemical Dependency Utilization – Fully Compliant**
- **Number of Consumers Moved from Institutional Care to Community Care – Fully Compliant**
- **Initiation and Engagement of Alcohol and other Drug Dependence Treatment – Substantially Compliant**
- **Utilization Management of the Provision of High Use Services – Fully Compliant**
- **Complaints/Grievances/Appeals – Fully Compliant**

The PIHP submitted a plan for corrective action for all of the recommendations to the EQRO (MPRO) by 10/31/06.

Problems identified: **EQR recommendations for the above two (2) Performance Measures found to be Substantially Compliant were for the PIHP to correct the denominators of both of these measures to account for the accurate enrollment requirements.**

Corrective action (plan/provider level): **The PIHP submitted a corrective action plan (CAP) for the above recommendation made by MPRO for the Validation of the Performance Measures and added criteria defining continuous enrollment to the script of both measures. The EQRO (MPRO) reviewed this CAP and found the Performance Measure Validation to be subsequently fully compliant, and amended the 2006 Performance Measure Validation report to show full compliance.**

Program change (system-wide level): **N/A**

(o) Strategy - Periodic Comparison of # of Providers: **Addressed in item g. above.**

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: **See item g above.**

Problems identified: **See item g above.**

Corrective action (plan/provider level): **See item g above.**

Program change (system-wide level): **See item g above.**

(q) Strategy - Provider Self-Report Data: **The PIHP completed a survey of network providers in May 2006 to determine their overall satisfaction with the Plan. The Community Research and Services division at UNC Charlotte's Urban Institute was contracted to administer the survey by mail. Out of 206 applicable providers to complete the survey, 80 surveys were returned, for a response rate of 38.8%.**

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: **Responses to the questionnaire were mixed, however, most favored strongly agree/agree for each of the statements in the areas of satisfaction.**

Access:

- **40.8% agreed that PBH Access staff are easily accessible**
- **45.3% of responses didn't know or were neutral when asked if Access staff has a good understanding of the services provided.**

Community Relations:

- **46.1% agreed that PBH conducts public education programs to make its presence known in the community.**
- **40.5% felt PBH works well with network providers and local community stakeholders.**
- **47.4% felt PBH places emphasis on the importance of culturally competent services.**

Consumer Affairs:

- **The majority of respondents replied that they did not know or were neutral to statements about setting a good example of empowerment and peer advocacy for consumers, and helping providers understand the consumer's point of view and right to self determination (57.8% and 57.1% respectively).**

Finance:

- **50.7% of respondents agreed that the Finance staff processes claims in a timely manner.**
- **44.2% felt the staff provided quality customer service.**

Information Systems:

- **44.7% agreed that Information Systems provided technical assistance in an efficient and timely manner.**
- **46.8% felt the staff of IS provided quality customer service.**

Network Management:

- **48.1% of providers agreed the monthly Provider Network Meetings are informative and helpful.**
- **57.2% felt they were successfully informed and 53.3% felt their requests were responded to in a timely and efficient manner.**
- **46.8% respondents agreed that Network staff were competent in providing technical assistance, information about the network and regarding best practices.**

Quality Management:

- **44.2% respondents agreed that the QM staff is helpful in explaining requirements and providing technical assistance.**
- **52.6% felt the QM staff are respectful and professional in their interactions.**
- **45.5% felt the staff responds to issues in a timely and efficient manner.**

Utilization Management:

- **40.3% agreed that the Utilization Management staff is helpful in explaining treatment and service options.**
- **63.6% respondents replied that they were aware of clinical guidelines for service.**

General:

- **50.7% felt PBH does business in an ethical manner with integrity.**
- **41.3% felt PBH personnel are qualified and competent in the performance of their jobs.**
- **55.2% felt PBH staff treats others with respect.**
- **48% felt PBH schedules meetings at convenient locations and times.**
- **43.4% felt PBH ensures services are available in all geographic areas served.**

<u>Problems identified:</u> Two statements in particular elicited mostly negative responses:

- **Authorization for services is timely (35.1%)**
- **Service availability in the network has improved since development of the Local Business Plan in my county (37.3%).**

The Consumer Affairs department had the most responses in the "don't know" category and when asked if "QM staff conducts fair and thorough investigations" the response "I don't know" received the largest response (36.5%).

<u>Corrective action (plan/provider level):</u> Each department within the Plan has reviewed the survey and has developed a plan as part of its ongoing CQI process. The director of Network Management will follow up with each director on the plans and report on status and findings at the Plan's CQI, Network Council, Provider, and the State Implementation meetings on a quarterly basis. In addition, the Plan is taking or has taken the following actions based on the survey results:

Ongoing Consumer Education/Information:

- **Consumer Affairs to speak to various provider groups on self determination**
- **Consumer Affairs to educate providers on their role**
- **Consumer Affairs to report on the CFAC as a standing agenda item at the provider meetings**
- **Consumer Affairs to seek network council input on what is important to cover in increasing awareness of consumer advocacy and support**
- **Community Relations to offer information to providers regarding educational programs that are underway through the stakeholder newsletter, through the provider meeting announcements, and on the PBH website (Provider Relations Section)**
- **Community Relations page will be developed on the PBH website**
- **Community Relations to offer regular updates on cultural competency at the monthly provider meetings as a standing agenda item**
- **Cultural Competence Conference being planned in February 2007**
- **The IS Department conducted a survey in August 2006 to evaluate ongoing training needs noted by the providers.**
- **Network has initiated a separate meeting for Licensed Independent Practitioners every two months which may be attended via web-ex and the use of virtual technology. Input related to the agenda is solicited on topics of interest to the providers in an attempt to have their unique questions answered and met. The meeting also solicits input on the process that day and opportunities for improvement.**
- **The Licensed Independent Practitioner Provider Relations Manager shall also initiate a newsletter "*Just for Licensed Independent Practitioners*"**
- **QM is working with the Network Council to finalize the Gold Star Provider Proposal which is anticipated to be implemented in January 2007**
- **PBH has centralized the Network Communications to providers which are developed by each subject matter specialist in the department, but then posted and sent out by the Provider Relations Department. The Official Network Communications become a part of the Provider Manual.**

Customer Services:

- **Customer Service is a Work Plan Goal for PBH and shall be a focus by all departments in 2006-2007**
- **Network Council has requested that PBH indicate the expectation that staff be responsive to provider inquiries in all departments within two business days and PBH Management Team has agreed to the following:**
    - **Management Team will convey this information to staff at the LME**
    - **LME Staff will acknowledge the telephone inquiry and if they are not able to answer the question shall give feedback that says when they can expect to receive an answer**
    - **LME staff will respond to e-mails in the same manner**
    - **PBH will explore the barriers that exist on the IS system related to the "the out of office message" being sent to external users. (PBH providers report that if they do not get a response, they are not aware that a staff person may be on vacation?)**
- **PBH has developed an internal customer service survey for QM which is being adapted by each department and will be randomly generated. It is anticipated that the survey will be adapted in 2006-2007 for external customers to provide further information on efforts in the area of customer service.**

- **Finance will continue to evaluate the "customer service log" to categorize customer concerns and ensure appropriate measure/training occurs**
- **Finance is developing an evaluation form after training for feedback and to implement improvements**
- **The IS Department has had a "*helpdesk tracking system*" for some time, but is now able to review the number of calls and do an analysis that allows review of the number of days to resolution, response time and compare that to the number of requests that are handled immediately**
- **Network has initiated the feedback after the Licensed Independent Practitioners (LIP) meetings**
- **LIP Provider Relations Manager has initiated site visits with providers to solicit their input on network membership, their needs, concerns and their feedback**
- **UM is working to train staff to provide better explanations to providers on UM actions and service alternatives**
- **PBH is working with Network Council on questions and answers for the provider network related to a number of topics and concerns. It is hoped that them more formalized process will assist with resolution**

Program change (system-wide level): **N/A**

(s) Strategy - Utilization Review

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: **The Piedmont Plan complied with data reporting as required. The PIHP submitted their initial annual statistical reporting measures, listed in Attachment N of the risk contract, on June 30, 2006 for the initial measurement period of April 1, 2005 through December 31, 2005. Submission of quarterly reporting measures started 45 days after the initial quarter of operation (data for first quarter 2005 was submitted by July 15, 2005). Quarterly reports have been submitted thereafter.**

Problems identified: **Throughout the data collection and reporting process, refinement in the reports was indicated and completed to ensure accuracy of the data. Initial data will be used as a baseline to establish goals in the subsequent year's Utilization Management Plan.**

As discussed above in item l, On-Site Review, Piedmont was providing statistical reporting to the State but was not using the reports to support UM.

Corrective action (plan/provider level): **Report development to support UM decisions is a component of the On-Site Review plan of correction discussed above in item l. The UM department has begun using the State-required statistical reports as a UM tool.**

Program change (system-wide level): N/A

Section D – Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

Appendix D1. Member Months
Appendix D2.S Services in the Actual Waiver Cost
Appendix D2.A Administration in the Actual Waiver Cost
Appendix D3. Actual Waiver Cost
Appendix D4. Adjustments in Projection
Appendix D5. Waiver Cost Projection
Appendix D6. RO Targets
Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: _*Aydlett Hunike*
c. Telephone Number:__*919 855 4208*_____
d. E-mail:_ *aydlett.hunike@ncmail.net* ___
e. The State is choosing to report waiver expenditures based on
_X_ date of payment.
__ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

a._X_ The State provides additional services under 1915(b)(3) authority.
b.___ The State makes enhanced payments to contractors or providers.
c._X_ The State uses a sole-source procurement process to procure State Plan services under this waiver.
d.___ Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in **A.I.b**.

a.___ MCO
b._X_ PIHP
c.___ PAHP
d.___ Other (please explain):

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a.___ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
  1.___ First Year: $____ per member per month fee
  2.___ Second Year: $____ per member per month fee
  3.___ Third Year: $____ per member per month fee
  4.___ Fourth Year: $____ per member per month fee

b.___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c.___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d.___ Other reimbursement method/amount. $_____ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

a.___ Population in the base year data
  1.___ Base year data is from the same population as to be included in the waiver.
  2. __ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b.___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

c.___ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: _____

d. ___ [Required] Explain any other variance in eligible member months from BY to P2: _____

e.____ [Required] List the year(s) being used by the State as a base year:____. If multiple years are being used, please explain:_____

f.____ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.

g.____ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data: _____

For Conversion or Renewal Waivers:

a._X_ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b._X_ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

c._X_ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

Enrollment projections are based on historical enrollment trends. The changes in enrollment are primarily due to changes in economic conditions and general increases in the population.

Below is a chart that summarizes the historical membership trends by quarter and MEG used as the basis for determining the P1 and P2 membership trends:

	MEG 01 AFDC	MEG 02 Blind/Disabled and Foster Children	MEG 03 Aged	MEG 04 CAP-MR	Total
Total	1.0%	0.7%	0.1%	1.7%	0.8%

d. _X_ [Required] Explain any other variance in eligible member months from BY/R1 to P2:

There are no other variances in the enrollment projections.

e._X__[Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:

R1 is April 1, 2005 through March 30, 2006. R2 is April 1, 2006 through March 30, 2007 (data currently available for R2 is for April 1, 2006 through June 30, 2006).

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers:

a.___ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

For Conversion or Renewal Waivers:

a._X_ [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**:

No differences from the amended Waiver submitted to CMS on September 1, 2006 and approved on December 6, 2006.

b._X_ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: _

CMS 64 reports are the basis for the cost effectiveness analysis. No services covered under the waiver are omitted from the cost-effectiveness analysis. Costs for services in the Innovations Program are included in the analysis. Pharmacy, which is a FFS impacted service, is also included. Acute care services not covered under the waiver (other than pharmacy) are excluded from the analysis.

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*

For Initial Waivers:

a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*Appendix D5 should reflect this.*		*Appendix D5 should reflect this.*

The allocation method for either initial or renewal waivers is explained below:

a.___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*

b._X_ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

In the CMS 64.10 report, the administration expenses for the Piedmont-area managed care program are not itemized separately from the States' total administrative costs. The State is working to address this in future CMS 64.10 report submissions. Because of this, we were not able to pull the administrative costs attributable to the managed care program directly off the report. Instead, the State allocated administrative costs to this waiver using the following calculation for each base year.

Total Medicaid Expenditures in R1:	**$8,882,975,214**
Total Medicaid Expenditures in R2:	**$2,251,813,091**
State Administrative Expenditures from CMS 64.10 in R1:	**$461,309,332**
State Administrative Expenditures from CMS 64.10 in R2:	**$123,636,867**

Since some of the administrative activities listed on the form are not directly related to the provision of MH/DD/SA services, it is necessary to remove certain costs from the total before allocation.

R1

Line 1 of CMS 64.10: Family Planning	***$49,907***
Line 5b: Mechanized Systems, not approved under MMIS:	***$8,335,483***
Line 9: Nurse Aid Training Costs:	***$591,411***
Line 11: Resident Review Activities Costs	***$445,006***

R2

Line 1 of CMS 64.10: Family Planning	***$10,678***
Line 5b: Mechanized Systems, not approved under MMIS:	***$1,943,049***
Line 9: Nurse Aid Training Costs:	***$139,096***
Line 11: Resident Review Activities Costs	***$332,501***

Admin Expenses not applicable for Piedmont BH Program in R1:	**$9,821,537**
Admin Expenses not applicable for Piedmont	

BH Program in R2:	**$2,482,936**
State Admin for allocation to Piedmont BH Program in R1:	**$451,487,795**
State Admin for allocation to Piedmont BH Program in R2:	**$121,153,961**
Total Expenditures for R1:	**$8,882,975,214**
Total Expenditures for R2:	**$2,251,813,091**
Admin % in R1 = (State Admin associated with Piedmont BH)/Total Expenditures:	**4.8%**
Admin % in R2 = (State Admin associated with Piedmont BH)/Total Expenditures:	**5.1%**
Piedmont Base Expenditures for R1:	**$106,795,596**
Piedmont Base Expenditures for R2:	**$29,791,411**
Allocated Admin for Piedmont in R1 (4.9% * $107M):	**$5,165,472**
Allocated Admin for Piedmont in R2 (5.1% * $30M):	**$1,521,027**

c.___ Other (Please explain).

H. Appendix D3 – Actual Waiver Cost

a._X_ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period

(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total			**(PMPM in Appendix D5 Column W x projected member months should correspond)**

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Because the waiver amendment requesting (b)(3) authority was submitted during R2 and CMS-64 data are only available for the first quarter of R2, information on the actual (b)(3) expenditures is not available. For purposes of waiver reporting, (b)(3) costs were allocated based on the allocations used in the last amendment to the previous waiver. The CMS 64 data available at this time reflects total capitation payments made to Piedmont, which include capitation funds which generated savings. The amendment was approved on December 6, 2006 and the funds attributable to savings will now be made available for (b)(3) services. Future amendments and renewals to this waiver will incorporate actual (b)(3) service experience.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
Respite	*$1,197,869 or $1.65 PMPM R1* *$1,356,635 or $1.79 PMPM R2*	7.33% or $99,413	$1,456,049 or $1.92 PMPM in P1 $1,563,278 or $2.07 PMPM in P2
Crisis Respite	*$1,088,971 or $1.50 PMPM R1* *$1,233,305 or $1.63 PMPM R2*	7.33% or $90,376	$1,323,680 or $1.75 PMPM in P1 $1,421,161 or $1.88 PMPM in P2
Supported Employment	*$1,633,457 or $2.25 PMPM R1* *$1,849,957 or $2.44 PMPM R2*	7.33% or $135,563	$1,985,521 or $2.62 PMPM in P1 $2,131,742 or $2.82 PMPM in P2
Individual Support	*$1,088,971 or $1.50 PMPM R1* *$1,233,305 or $1.63 PMPM R2*	7.33% or $90,376	$1,323,680 or $1.75 PMPM in P1 $1,421,161 or $1.88 PMPM in P2

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
Community Transition Services	*$108,897 or $0.15 PMPM R1* *$123,330 or $0.16 PMPM R2*	7.33% or $9,038	$132,368 or $0.17 PMPM in P1 $142,116 or $0.19 PMPM in P2
Peer Supports	*$1,415,663 or $1.95 PMPM R1* *$1,603,296 or $2.12 PMPM R2*	7.33% or $117,488	$1,720,785 or $2.27 PMPM in P1 $1,847,510 or $2.44 PMPM in P2
Innovations Waiver Services	*$2,722,429 or $3.75 PMPM R1* *$3,083,262 or $4.07 PMPM R2*	7.33% or $225,939	$3,309,201 or $4.37 PMPM in P1 $3,552,903 or $4.70 PMPM in P2
Community Reinvestment Fund	*$2,201,111 or $3.03 PMPM R1* *$2,492,848 or $3.29 PMPM R2*	7.33% or $182,674	$2,675,522 or $3.54 PMPM in P1 $2,872,558 or $3.80 PMPM in P2
Total	*$11,457,368 or $15.77 PMPM R1* *$12,975,940 or $17.15 PMPM R2*	**7.33% or $950,866**	**$13,926,806 or $18.41 PMPM in P1** **$14,952,429 or $19.76 PMPM in P2** **(PMPM in Appendix D5 Column W x projected member months should correspond)**

b.___ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c._X_ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1.___ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

2._X_ The State provides stop/loss protection (please describe):

The State's contract with Piedmont contains a requirement for a risk and contingency account. The State will explicitly include 2% in the administrative portion of the capitated rate to fund this account. This account will accumulate up to a maximum of 15% and be used to fund periodic shortfalls in capitation revenue if monthly expenses exceed revenue. Given this arrangement, the State has chosen not to require additional stop/loss protection for this program.

d._NA_Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1.___ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost).** Regular State Plan service capitated adjustments would apply.

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

2._NA For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special

criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the preprint

I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _____. Please document how that trend was calculated:

2.___ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future)*.

i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii.____ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used_____. Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. __ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.___ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.

For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ Changes brought about by legal action (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

iv.__ Changes in legislation (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

v.__ Other (please describe):
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

c.___ **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2.___ An administrative adjustment was made.

i.___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
A.____ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
B.____ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
C.____ Other (please describe):

ii.___ FFS cost increases were accounted for.

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____Other (please describe):

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future),* the State must use the State's trend for State Plan Services.

i. State Plan Service trend

A. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.I.a**._____

2. List the Incentive trend rate by MEG if different from **Section D.I.I.a _____**
3. Explain any differences:

f. **Graduate Medical Education (GME) Adjustment**: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1.___ We assure CMS that GME payments are included from base year data.
2.___ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)
3.___ Other (please describe):

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1.___ GME adjustment was made.
   i.___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).
   ii.___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).
2.___ No adjustment was necessary and no change is anticipated.

Method:

1.___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine GME adjustment based on a pending SPA.
3.___ Determine GME adjustment based on currently approved GME SPA.
4.___ Other (please describe):

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5.**

1.___ Payments outside of the MMIS were made. Those payments include (please describe):
2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3.___ The State had no recoupments/payments outside of the MMIS.

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.
Basis and Method:

1.___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.

2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3.___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4.___ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.
1.___ No adjustment was necessary and no change is anticipated.
2___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:
1.___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine copayment adjustment based on pending SPA.
3.___ Determine copayment adjustment based on currently approved copayment SPA.
4.___ Other (please describe):

i. **Third Party Liability (TPL) Adjustment**: This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.
Basis and method:
1.___ No adjustment was necessary
2.___ Base Year costs were cut with post-pay recoveries already deducted from the database.
3.___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4.___ The State made this adjustment:*
i.___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
ii.___ Other (please describe):

j. **Pharmacy Rebate Factor Adjustment** : Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.
Basis and Method:
1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1.___ We assure CMS that DSH payments are excluded from base year data.

2.___ We assure CMS that DSH payments are excluded from the base year data using an adjustment.

3.___ Other (please describe):

l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1.___ This adjustment is not necessary as there are no voluntary populations in the waiver program.

2.___ This adjustment was made:

a. ___Potential Selection bias was measured in the following manner:

b.___The base year costs were adjusted in the following manner:

m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:

2.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.

3.___ ***We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.***

4.___ Other (please describe):

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs:

The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double

payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a.___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

b.___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

Special Note for initial combined waivers (Capitated and PCCM) only:
Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	**Capitated Program**	**PCCM Program**
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported (IBNR) factors,” or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*

1.___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:
2.___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
3.___ Other (please describe):

o. **PCCM Case Management Fees (Initial PCCM waivers only) –** The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5.**
1.___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
2.___ This adjustment was made in the following manner:

p. **Other adjustments**: Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

  1.___ No adjustment was made.
  2.___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D4 -- Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost

changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1._X_ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _7.33% in P1 and 7.36% in P2__. Please document how that trend was calculated:

For base periods R1 and R2, 15 months of experience for the managed care program has been reported. The annualized service trend level contained in Appendix D.3 shows an overall growth rate of 11.1% using R1 and R2 reported waiver expenditures. Due to the limited amount of reported managed care experience, Mercer decided to supplement this data. Mercer also used FFS data for the counties in North Carolina that are not in managed care. This data provided a more robust data set for trend analysis and was the primary source for the waiver and rate-setting trend review.

Mercer developed trend by Category of Service (COS) and Medicaid Eligibility Group. Trend is set in total, considering both unit cost inflation and utilization. The trend projections in the cost effectiveness spreadsheets are consistent with the trend assumptions that will be used to develop the rates for the first waiver year April 1, 2007 to March 31, 2008 (P1).

Mercer considers historical year over year trends, as well as rolling averages in making these estimates. In addition to North Carolina-specific data sources, Mercer also considers national indices (Consumer Price Index, Producer Price Index and Data Resource, Inc.). No adjustments for programmatic, policy, or pricing changes were necessary; therefore, trend estimates do not duplicate the effect of any changes.

The following chart illustrates the weighted averages of the Capitated PIHP services and Wraparound Pharmacy trends.

Chart: Weighted Average Trend Assumptions

Service Grouping	Actual FFS Experience
BH/DD services covered by PIHP	7.6%
Pharmacy (FFS wraparound)	7.0%
Weighted Average Trend Rates	P1: 7.33% P2: 7.36%

2.___ [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future).*

i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii. ___ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _____. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. _X__ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior*

approval of capitation rates is contingent upon approval of the SPA. The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1._X_ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.___ An adjustment was necessary and is listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Determine adjustment for Medicare Part D dual eligibles.
E.____ Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv.__ Changes brought about by legal action (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

v.__ Changes in legislation (please describe):

For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

vi.__ Other (please describe):

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

c.___ **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2._X_ An administrative adjustment was made.

i.___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

ii.___ Cost increases were accounted for.

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:

D.____Other (please describe):

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate

or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_R1 and R2_ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

The annualized administrative cost trend rate contained in Appendix D.3 is 21.72%.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _7.33% in P1 and 7.36% in P2_.

Since the trend rates in subsection B are lower, the State will use the overall State Plan Service trends as the basis for projecting administrative costs during the waiver period.

The quarterly CMS 64 reports have shown volatility in administrative costs. Of the four quarters in R1, two have higher administrative expenses than in the first quarter of R1 and two have lower expenses. The first and only available quarter of R2 shows a relatively high administrative expense but is reasonable compared to the two higher quarterly amounts in R1. Due to this volatility, we have assumed administrative costs will grow at the same rate as the State Plan Services.

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present)*. The actual documented trend is: _____. Please provide documentation.

2._X_ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years___N/A_____

Historical 1915(b)(3) service costs are unavailable at this time due to the timing of the waiver amendment and the submission of this waiver renewal. Any future amendments and renewals will incorporate actual (b)(3) service cost experience.

2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _7.33% in P1 and 7.36% in P2_.

Historical data for (b)(3) service costs is currently unavailable. For this reason, the State is using the State Plan Services trend, which includes prescription drug costs, noted in the chart in Section D.I.J.a previously.

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____

2. List the Incentive trend rate by MEG if different from **Section D.I.J.a**. _____

3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)***: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as

the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

1.___ _X_ No adjustment was made.

2.___ ___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

Enrollment projections are based on historical enrollment trends.

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

In developing trend for the time periods from R2 to P1 and from P1 to P2, estimates were based primarily on historical FFS and managed care data, with consideration for other data sources such as CPI and DRI. Changes in utilization and unit cost were considered together in developing trend. The trends used are consistent with historical changes in cost and utilization in North Carolina's Medicaid program.

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I.**

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.

State of North Carolina **Appendix D1. Member Months** .

Row # / Column Letter

Renewal Waiver

Estimated Member Month Calculations

State: **North Carolina**

Actual Enrollment for the Time Period - R1 = 4/1/2005 through 3/31/2005 R2 = 4/1/2006 through 6/30/2006 **R1 and R2 include actual data and dates. No estimates. Minimum 5 Quarters needed for worksheet.

Enrollment Projections for the Time Period - P1 = 4/1/2007 through 3/31/2008 P2 = 4/1/2008 through 3/31/2009 *Projections start on a calendar quarter and include data for the entire requested waiver period

Medicaid Eligibility Group (MEG)	Retrospective Year 1 (R1) ends	Retrospective Year 2 (R2) ends	Projected Quarter 1 begins	Projected Quarter 2 begins	Projected Quarter 3 begins	Projected Quarter 4 begins	Projected Year 1	Projected Quarter 5 begins	Projected Quarter 6 begins	Projected Quarter 7 begins	Projected Quarter 8 begins	Projected Year 2	Total Projected
	3/31/2005	6/30/2006	4/1/2007	7/1/2007	10/1/2007	1/1/2008	(P1)	4/1/2008	7/1/2008	10/1/2008	1/1/2009	(P2)	(H+M)
AFDC	477,167	126,245	131,371	132,685	134,012	135,352	533,420	136,705	138,072	139,453	140,848	555,078	1,088,498
Blind/Disabled and Foster Children	154,145	39,151	40,259	40,541	40,824	41,110	162,734	41,398	41,688	41,980	42,273	167,339	330,073
Aged	90,220	22,449	22,539	22,561	22,584	22,607	90,291	22,629	22,652	22,675	22,697	90,653	180,944
CAP-MR	4,840	1,319	1,411	1,435	1,459	1,484	5,789	1,509	1,535	1,561	1,588	6,193	11,982
Total Member Months	**726,372**	**189,164**	**195,580**	**197,222**	**198,879**	**200,553**	**792,234**	**202,241**	**203,947**	**205,669**	**207,406**	**819,263**	**1,611,497**
Quarterly % Increase				**0.84%**	**0.84%**	**0.84%**		**0.84%**	**0.84%**	**0.84%**	**0.84%**		
Annualized % Increase R1 to R2 to P1 to P2		**6.75%**					**4.70%**					**3.41%**	

Note tabs at bottom of spreadsheet - to print all charts select 'Entire Workbook' from print options.

Modify Line items as necessary to fit the MEGs of the program.

*Projections start on a calendar quarter and include data for the entire requested waiver period

**R1 and R2 include actual data and dates. No estimates. A minimum of 5 quarters of actual data is needed for these worksheets to calculate properly

NUMBER OF DAYS OF DATA	
R2	90.00
Gap (end of R2 to P1)	275.00
P1	365.00
P2	364.00
TOTAL R2 to P2	1094
(Days-365)	729
TOTAL R2 to P1	730
(Days-364)	365

State Completion Sections — Enter R1 and R2 counts from completed member months reports submitted to RO on quarterly basis.

Project P1 and P2 on a quarterly basis using R2 as base.

To modify the formulas as necessary to fit the length of the program complete this section. The formulas will automatically update given this data.

Use Quarter Starting Dates on Appendix D1. Appendix D6 will automatically become Quarter Ending Dates to sync with CMS-64.

Note: the calculations in the worksheet use greater detail than what is shown in printed tables or on the screen. This results in greater precision than if all calculations were rounded to the displayed currency settings. Using a calculator for hand calculation will show differences when summing larger numbers - the differences should not be significant.

Row # / Column Letter | B | C | D | E | F | G

Services in Actual Waiver Cost (Comprehensive and Expedited)
State of North Carolina
Base Year Conversion Renewal

State Plan Services			All MEGS		
Service Category	State Plan Approved Services	1915(b)(3) Services	MCO Capitated Reimbursement	FFS services Impacted by MCO	PCCM Fee-for-Service Reimbursement
Inpatient (includes psych)	x		x		
Community Based Services	x		x		
High Risk Intervention Residential	x		x		
Case Management	x		x		
Assertive Community Treatment	x		x		
Outpatient (includes psych)	x		x		
CAP-MR	x		x		
ICF-MR	x		x		
Other Mental Health Services	x		x		
Prescribed Drugs	x			x	
Respite		x	x		
Crisis Respite		x	x		
Supported Employment		x	x		
Individual Support		x	x		
Community Transition Services		x	x		
Peer Supports		x	x		
Innovations Waiver Services		x	x		

Administration in Actual Waiver Cost (Comprehensive and Expedited)

State: North Carolina

Renewal Waiver

Instructions: Modify columns as applicable to the waiver entity type and structure to note administration in different MEGs, etc.

CMS 64.10 line Item	CMS 64.10 Explanation	Contract	Match Rate	Allocated from CMS 64.10 R1 Expenses	Allocated from CMS 64.10 R2 Expenses
1	FAMILY PLANNING		90% FFP	$ -	$ -
2	DESIGN DEVELOPMENT OR INSTALLATION OF MMIS*		90% FFP	$ -	$ -
A.	COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS		90% FFP	$ 5,212.76	$ 11,524.36
B.	COST OF PRIVATE SECTOR CONTRACTORS		90% FFP	$ 197,218.49	$ 30,335.54
C.	DRUG CLAIMS SYSTEM		90% FFP	$ -	$ -
3	SKILLED PROFESSIONAL MEDICAL PERSONNEL		75% FFP	$ 535,721.71	$ 101,235.79
4	OPERATION OF AN APPROVED MMIS*:		75% FFP	$ -	$ -
A.	COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS		75% FFP	$ 58,427.52	$ 45,116.26
B.	COST OF PRIVATE SECTOR CONTRACTORS		75% FFP	$ 321,275.40	$ 107,448.60
5	MECHANIZED SYSTEMS, NOT APPROVED UNDER MMIS PROCEDURES:		50% FFP	$ -	$ -
A.	COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS		50% FFP	$ 7,485.06	$ 1,182.51
B.	COST OF PRIVATE SECTOR CONTRACTORS		50% FFP	$ -	$ -
6	PEER REVIEW ORGANIZATIONS (PRO)		75% FFP	$ 33,018.72	$ 8,792.74
7. A.	THIRD PARTY LIABILITY RECOVERY PROCEDURE - BILLING OFFSET		50% FFP	$ -	$ -
B.	ASSIGNMENT OF RIGHTS - BILLING OFFSET		50% FFP	$ -	$ -
8	IMMIGRATION STATUS VERIFICATION SYSTEM COSTS		100% FFP	$ -	$ -
9	NURSE AIDE TRAINING COSTS		50% FFP	$ -	$ -
10	PREADMISSION SCREENING COSTS		75% FFP	$ -	$ -
11	RESIDENT REVIEW ACTIVITIES COSTS		75% FFP	$ -	$ -
12	DRUG USE REVIEW PROGRAM		75% FFP	$ -	$ -
13	OUTSTATIONED ELIGIBILITY WORKERS		50% FFP	$ -	$ -
14.	TANF BASE		90% FFP	$ -	$ -
15.	TANF SECONDARY 90%		90% FFP	$ -	$ -
16.	TANF SECONDARY 75%		75% FFP	$ -	$ -
17.	EXTERNAL REVIEW		75% FFP	$ -	$ -
18.	ENROLLMENT BROKERS		50% FFP	$ -	$ -
19.	OTHER FINANCIAL PARTICIPATION		50% FFP	$ 4,007,112.43	$ 1,215,391.05
20	Total			**$ 5,165,472.09**	**$ 1,521,026.85**

*Allocation basis is ___% of Medicaid costs OR ___ % of Medicaid eligibles OR ___ other, please explain:

Add multiple line items as necessary to fit the administration of the program (i.e. if you have more than one contract on line 19, detail the contracts separately).

State Completion Sections Enter in amounts from Schedule F on the MBES system.

Row # / Column Letter | B | C | D | E | F | G | H | I | J | K

Actual Waiver Cost Renewal Comprehensive Version — **Actual Waive**

State: North Carolina

Medicaid Eligibility Group (MEG)	R1 Member Months	Retrospective Year 1 (R1) Aggregate Costs: MCO/PIHP Capitated Costs (Including incentives and risksharing payouts/withholds) or PCCM Case Management Fees	Fee-for-Service Costs	State Plan Service Costs (D+E)	FFS Incentive Costs (not included in capitation rates, provide documentation)	1915(b)(3) service costs (provide documentation)	Administration Costs	Total Actual Waiver Costs (F+G+H+I)	State Plan Service Costs (F/C)
AFDC	477,167	$ 11,353,119	$ 4,221,099	$ 15,574,218		$ 1,545,132	$ 3,393,293	**$ 20,512,643**	$ 32.64
Blind/Disabled and Foster Children	154,145	$ 42,200,401	$ 8,802,030	$ 51,002,431		$ 8,300,883	$ 1,096,176	**$ 60,399,490**	$ 330.87
Aged	90,220	$ 1,972,925	$ 2,737,369	$ 4,710,294		$ 204,637	$ 641,584	**$ 5,556,515**	$ 52.21
CAP-MR	4,840	$ 23,620,878	$ 430,407	$ 24,051,285		$ 1,406,716	$ 34,419	**$ 25,492,420**	$ 4,969.27
Total	**726,372**	**$ 79,147,323**	**$ 16,190,905**	**$ 95,338,228**	**$ -**	**$ 11,457,368**	**$ 5,165,472**	**$ 111,961,068**	
R1 Overall PMPM Casemix for R1 (R1 MMs)									**$ 131.25**

Medicaid Eligibility Group (MEG)	R2 Member Months	Retrospective Year 2 (R2) Aggregate Costs: MCO/PIHP Capitated Costs (Including incentives and risksharing payouts/withholds) or PCCM Case Management Fees	Fee-for-Service Costs	State Plan Service Costs (D+E)	FFS Incentive Costs (not included in capitation rates, provide documentation)	1915(b)(3) service costs (provide documentation)	Administration Costs (Attach list using CMS 64.10 Waiver schedule categories)	Total Actual Waiver Costs (F+G+H+I)	State Plan Service Costs (F/C)
AFDC	126,245	$ 3,678,136	$ 1,341,328	$ 5,019,464		$ 449,324	$ 1,015,109	**$ 6,483,897**	$ 39.76
Blind/Disabled and Foster Children	39,151	$ 12,737,725	$ 1,554,152	$ 14,291,877		$ 2,317,331	$ 314,805	**$ 16,924,013**	$ 365.04
Aged	22,449	$ 601,890	$ 38,243	$ 640,133		$ 55,967	$ 180,508	**$ 876,608**	$ 28.52
CAP-MR	1,319	$ 6,508,146	$ 87,806	$ 6,595,952		$ 421,363	$ 10,606	**$ 7,027,921**	$ 5,000.72
Total	**189,164**	**$ 23,525,897**	**$ 3,021,529**	**$ 26,547,426**	**$ -**	**$ 3,243,985**	**$ 1,521,027**	**$ 31,312,438**	
R1 Overall PMPM Casemix for R2 (R2 MMs)									**$ 140.34**

Modify Line items as necessary to fit the MEGs of the program.

State Completion Sections: For a State without FFS incentives or 1915(b)(3), enter in amounts from Schedule F from the MBES (Capitated - Column D versus FFS - Column E) and ensure that Column F matches services costs in Schedule D from the MBES.
If the State has 1915(b)(3) or FFS incentives, use State ad hoc reports to calculated amountes in Columns G and H and to reduce the amounts in columns D and E.
For these comprehensive states, the total from Columns D, E, G, and H should equal the services amounts in Schedule D from the MBES.
Note: The States completing the Expedited Test will only attach the most recent waiver Schedule D, and the corresponding quarters of waiver forms from the CMS-64.9 Waiver and CMS-64.21U Waiver and CMS 64.10 Waiver.
Completion of this Appendix is not necessary for expedited waivers.
Note: The States completing the Comprehensive Test will attach the most recent waiver Schedule D, and the corresponding quarters of waiver forms from the CMS-64.9 Waiver and CMS-64.21U Waiver and CMS 64.10 Waiver.
Completion of this Appendix is required for Comprehensive Waivers.

Appendix D3. Actual Waiver Cost

Row # / Column Letter | B | C | L | M | N | O

er Cost Renewal Comprehensive Version

State: North Carolina

Medicaid Eligibility Group (MEG)	R1 Member Months	R1 Per Member Per Month (PMPM) Costs: Incentive Costs (G/C)	1915(b)(3) Service Costs (H/C)	Administration Costs (I/C)	Total Actual Waiver Costs (J/C)
AFDC	477,167	$ -	$ 3.24	$ 7.11	**$ 42.99**
Blind/Disabled and Foster Children	154,145	$ -	$ 53.85	$ 7.11	**$ 391.84**
Aged	90,220	$ -	$ 2.27	$ 7.11	**$ 61.59**
CAP-MR	4,840	$ -	$ 290.64	$ 7.11	**$ 5,267.03**
Total	**726,372**				
R1 Overall PMPM Casemix for R1 (R1 MMs)		**$ -**	**$ 15.77**	**$ 7.11**	**$ 154.14**

Medicaid Eligibility Group (MEG)	R2 Member Months	R2 Per Member Per Month (PMPM) Costs: Incentive Costs (G/C)	1915(b)(3) Service Costs (H/C)	Administration Costs (I/C)	Total Actual Waiver Costs (J/C)	Adm Trend	Service Trend
AFDC	126,245	$ -	$ 3.56	$ 8.04	**$ 51.36**	**21.72%**	**37.13%**
Blind/Disabled and Foster Children	39,151	$ -	$ 59.19	$ 8.04	**$ 432.28**	**21.72%**	**17.03%**
Aged	22,449	$ -	$ 2.49	$ 8.04	**$ 39.05**	**21.72%**	**-62.01%**
CAP-MR	1,319	$ -	$ 319.46	$ 8.04	**$ 5,328.22**	**21.72%**	**1.01%**
Total	**189,164**						
R1 Overall PMPM Casemix for R2 (R2 MMs)		**$ -**	**$ 17.15**	**$ 8.04**	**$ 165.53**	**21.72%**	**11.31%**

Modify Line items as necessary to fit the MEGs of the program.

State Completion Sections: For a State without FFS incentives or 1915(b)(3), enter in
If the State has 1915(b)(3) or FFS incentives, use State ad hoc reports to calculated
For these comprehensive states, the total from Columns D, E, G, and H should equal
Note: The States completing the Expedited Test will only attach the most recent waiv
Completion of this Appendix is not necessary for expedited waivers.
Note: The States completing the Comprehensive Test will attach the most recent wai
Completion of this Appendix is required for Comprehensive Waivers.

Row # / Column Letter | B | C | D

Adjustments and Services in Waiver Cost Projection (Comprehensive and Expedited)

State: North Carolina

Prospective Years 1 and 2 (P1 and P2)

Renewal Waiver

*** If a change please note**

Adjustments to the Waiver Cost Projection	Adjustments Made	Location of Adjustment
State Plan Trend	X	Tab: D5; Column: J; Rows: 13-16, 30-33
State Plan Programmatic/policy/pricing changes		
Administrative Cost Adjustment		
1915(b)(3) service Trend	x	Tab: D5; Column: U; Rows: 13-16, 30-33
Incentives (not in cap payment) Adjustments		
Other		

State Completion Sections

Waiver Cost Projection Renewal Waiver Comprehensive Version
State: North Carolina
Note: Complete this Appendix for all Prospective Years
Waiver Cost Projection

Medicaid Eligibility Group (MEG)	Retrospective Year 2 (R2) Member Months	R2 Per Member Per Month (PMPM) Costs: State Plan Service Costs*	Incentive Costs*	1915(b)(3) Service Costs*	Administration Costs*	Total Actual Waiver Costs*	Prospective Year 1 (P1) Projection for State Plan Services**: R2 PMPM State Plan Service Costs* (Same as D13-D18)	State Plan Inflation Adjustment (Annual Year 1) (Preprint Explains)	PMPM Effect of Inflation Adjustment (IxJ)	Program Adjustment (Preprint Explains)	PMPM Effect of Program Adjustment ((I+K)xL)	Aggregate PMPM Effect of State Plan Service Adj. (K+M)	Total P1 PMPM State Plan Service Cost Projection (I+N)
AFDC	126,245	$ 39.76	$ -	$ 3.56	$ 8.04	$ 51.36	$ 39.76	9.60%	$ 3.82	0.0%	$ -	$ 3.82	$ 43.58
Blind/Disabled and Foster Children	39,151	$ 365.04	$ -	$ 59.19	$ 8.04	$ 432.28	$ 365.04	7.90%	$ 28.84	0.0%	$ -	$ 28.84	$ 393.88
Aged	22,449	$ 28.52	$ -	$ 2.49	$ 8.04	$ 39.05	$ 28.52	10.00%	$ 2.85	0.0%	$ -	$ 2.85	$ 31.37
CAP-MR	1,319	$ 5,000.72	$ -	$ 319.46	$ 8.04	$ 5,328.22	$ 5,000.72	4.10%	$ 205.03	0.0%	$ -	$ 205.03	$ 5,205.75
Total	**189,164**												
P1 PMPM Casemix for R2 (R2 MMs)		**$ 140.34**	**$ -**	**$ 17.15**	**$ 8.04**	**$ 165.53**	**$ 140.34**	**7.33%**	**$ 10.28**	**0.0%**	**$ -**	**$ 10.28**	**$ 150.62**

* For comprehensive waivers, Columns D, E, F, G and H are columns K, L, M, N, and O from the Actual Waiver Cost Spreadsheet D3. For expedited waivers, sum the CMS-64.9 WAV and 64.21UWAV forms and divide by the member months for column D. Sum the CMS 64.10 WAV forms and divide by the member months for Column G. Sum D+G for Column H.
** If additional columns are needed in order to identify all of the adjustments being made, please insert the appropriate number of columns and label them accordingly.

Medicaid Eligibility Group (MEG)	Retrospective Year 2 (R2) Member Months	P1 Per Member Per Month (PMPM) Costs: P1 PMPM State Plan Service Costs (same as O13-O18)	P1 PMPM Incentive Service Costs (same as S13-S18)	P1 PMPM 1915(b)(3) Service Costs (same as W13-W18)	P1 PMPM Administration Service Costs (same as AA13-AA18)	P1 PMPM Total Actual Waiver Costs (same as AB13-AB18)	Prospective Year 2 (P2) Projection for State Plan Services**: P1 PMPM State Plan Service Cost Projection (Same as D30-D35)	State Plan Inflation Adjustment (Annual Year 2) (Preprint Explains)	PMPM Effect of Inflation Adjustment (IxJ)	Program Adjustment (Preprint Explains)	PMPM Effect of Program Adjustment ((I+K)xL)	Aggregate PMPM Effect of State Plan Service Adj. (K+M)	Total P2 PMPM State Plan Service Cost Projection (I+N)
AFDC	126,245	$ 43.58	$ -	$ 3.82	$ 8.63	$ 56.03	$ 43.58	9.60%	$ 4.18	0.0%	$ -	$ 4.18	$ 47.76
Blind/Disabled and Foster Children	39,151	$ 393.88	$ -	$ 63.53	$ 8.63	$ 466.04	$ 393.88	7.90%	$ 31.12	0.0%	$ -	$ 31.12	$ 425.00
Aged	22,449	$ 31.37	$ -	$ 2.68	$ 8.63	$ 42.67	$ 31.37	10.00%	$ 3.14	0.0%	$ -	$ 3.14	$ 34.50
CAP-MR	1,319	$ 5,205.75	$ -	$ 342.87	$ 8.63	$ 5,557.25	$ 5,205.75	4.10%	$ 213.44	0.0%	$ -	$ 213.44	$ 5,419.19
Total	**189,164**												
P2 PMPM Casemix for R2 (R2 MMs)		**$ 150.62**	**$ -**	**$ 18.41**	**$ 8.63**	**$ 177.66**	**$ 150.62**	**7.36%**	**$ 11.09**	**0.0%**	**$ -**	**$ 11.09**	**$ 161.72**

Modify Line items as necessary to fit the MEGs of the program.

Actual Waiver Cost Conversion Renewal Comprehensive Version

State: North Carolina

Note: Complete this Appendix for all Prospective Years

Waiver Cost Projection

Medicaid Eligibility Group (MEG)	P1 Projection for Incentive Costs not Included in Capitation Rates**				P1 Projection for 1915(b)(3) Service Costs**				P1 Projection for Administration Costs**				Total P1 PMPM Projected Waiver Costs (O+S+W+AA)
	R2 PMPM Incentive Costs* (Same as E13-E18)	Incentive Cost Inflation Adj. (Annual Year 1) (Preprint Explains)	PMPM Effect of Inflation Adjustment (PxQ)	Total P1 PMPM Incentive Cost Projection (P+R)	R2 PMPM 1915(b)(3) Service Costs* (Same as F13-F18)	1915(b)(3) Service Costs Inflation Adj. (Annual Year 1) (Preprint Explains)	PMPM Effect of Inflation Adjustment (TxU)	Total P1 PMPM 1915(b)(3) Service Cost Projection (T+V)	R2 PMPM Administration Costs* (Same as G13-G18)	Administration Costs Inflation Adj. (Annual Year 1) (Preprint Explains)	PMPM Effect of Inflation Adjustment (XxY)	Total P1 PMPM Administration Cost Projection (X+Z)	
AFDC	$ -		$ -	$ -	$ 3.56	7.33%	$ 0.26	$ 3.82	$ 8.04	7.33%	$ 0.59	$ 8.63	**$ 56.03**
Blind/Disabled and Foster Children	$ -		$ -	$ -	$ 59.19	7.33%	$ 4.34	$ 63.53	$ 8.04	7.33%	$ 0.59	$ 8.63	**$ 466.04**
Aged	$ -		$ -	$ -	$ 2.49	7.33%	$ 0.18	$ 2.68	$ 8.04	7.33%	$ 0.59	$ 8.63	**$ 42.67**
CAP-MR	$ -		$ -	$ -	$ 319.46	7.33%	$ 23.41	$ 342.87	$ 8.04	7.33%	$ 0.59	$ 8.63	**$ 5,557.25**
Total													
P1 PMPM Casemix for R2 (R2 MMs)	**$ -**	**0.00%**	**$ -**	**$ -**	**$ 17.15**	**7.33%**	**$ 1.26**	**$ 18.41**	**$ 8.04**	**7.33%**	**$ 0.59**	**$ 8.63**	**$ 177.66**

Medicaid Eligibility Group (MEG)	P2 Projection for Incentive Costs not Included in Capitation Rates**				P2 Projection for 1915(b)(3) Service Costs**				P2 Projection for Administration Costs**				Total P2 PMPM Projected Waiver Costs (O+S+W+AA)
	P1 PMPM Incentive Cost Projection (Same as E30-E35)	Incentive Cost Inflation Adj. (Annual Year 2) (Preprint Explains)	PMPM Effect of Inflation Adjustment (PxQ)	Total P2 PMPM Incentive Cost Projection (P+R)	P1 PMPM 1915(b)(3) Service Cost Projection (Same as F30-F35)	1915(b)(3) Service Costs Inflation Adj. (Annual Year 2) (Preprint Explains)	PMPM Effect of Inflation Adjustment (TxU)	Total P2 PMPM 1915(b)(3) Service Cost Projection (T+V)	P1 PMPM Administration Cost Projection (Same as G30-G35)	Administration Costs Inflation Adj. (Annual Year 2)	PMPM Effect of Inflation Adjustment (XxY)	Total P2 PMPM Administration Cost Projection (X+Z)	
AFDC	$ -		$ -	$ -	$ 3.82	7.36%	$ 0.28	$ 4.10	$ 8.63	7.36%	$ 0.64	$ 9.27	**$ 61.13**
Blind/Disabled and Foster Children	$ -		$ -	$ -	$ 63.53	7.36%	$ 4.68	$ 68.21	$ 8.63	7.36%	$ 0.64	$ 9.27	**$ 502.47**
Aged	$ -		$ -	$ -	$ 2.68	7.36%	$ 0.20	$ 2.87	$ 8.63	7.36%	$ 0.64	$ 9.27	**$ 46.64**
CAP-MR	$ -		$ -	$ -	$ 342.87	7.36%	$ 25.25	$ 368.12	$ 8.63	7.36%	$ 0.64	$ 9.27	**$ 5,796.57**
Total													
P2 PMPM Casemix for R2 (R2 MMs)	**$ -**	**0.00%**	**$ -**	**$ -**	**$ 18.41**	**7.36%**	**$ 1.36**	**$ 19.76**	**$ 8.63**	**7.36%**	**$ 0.64**	**$ 9.27**	**$ 190.74**

Modify Line items as necessary to fit the MEGs of the program.

Quarterly CMS Targets for RO Monitoring

State: North Carolina

Projection for Upcoming Waiver Period

Projected Year 1

Medicaid Eligibility Group (MEG)	Total Projected Year 1 Member Months (P1)	P1 Projected PMPM Costs from Appendix D5 (Totals weighted on Projected Year 1 Member Months)					Total PMPM Projected Service Costs (Column H-G)
		Total PMPM State Plan Service Cost Projection	Total PMPM Incentive Cost Projection	Total PMPM 1915(b)(3) Service Cost Projection	Total PMPM Administration Cost Projection	Total PMPM Projected Waiver Costs	
AFDC	533,420	$ 43.58	$ -	$ 3.82	$ 8.63	$ 56.03	$ 47.40
Blind/Disabled and Foster Children	162,734	$ 393.88	$ -	$ 63.53	$ 8.63	$ 466.04	$ 457.41
Aged	90,291	$ 31.37	$ -	$ 2.68	$ 8.63	$ 42.67	$ 34.04
CAP-MR	5,789	$ 5,205.75	$ -	$ 342.87	$ 8.63	$ 5,557.25	$ 5,548.62
Total	**792,234**						
P1 Weighted Average PMPM Casemix for P1 (P1 MMs)		**$ 151.86**	**$ -**	**$ 18.43**	**$ 8.63**	**$ 178.92**	

Medicaid Eligibility Group (MEG)	Q1 Quarterly Projected Costs			Q2 Quarterly Projected Costs			Q3 Quarterly Projected Costs			Q4 Quarterly Projected Costs			Total P1 Projected Waiver Costs
	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	
AFDC	131,371	$ 6,226,537.57	$ 1,133,732.54	132,685	$ 6,288,816.69	$ 1,145,072.36	134,012	$ 6,351,711.97	$ 1,156,524.38	135,352	$ 6,415,223.40	$ 1,168,088.59	**$ 29,885,707.50**
Blind/Disabled and Foster Children	40,259	$ 18,414,889.28	$ 347,435.42	40,541	$ 18,543,879.04	$ 349,869.08	40,824	$ 18,673,326.21	$ 352,311.37	41,110	$ 18,804,145.61	$ 354,779.55	**$ 75,840,635.56**
Aged	22,539	$ 767,278.33	$ 194,511.71	22,561	$ 768,027.26	$ 194,701.57	22,584	$ 768,810.23	$ 194,900.06	22,607	$ 769,593.20	$ 195,098.55	**$ 3,852,920.90**
CAP-MR	1,411	$ 7,829,098.96	$ 12,176.94	1,435	$ 7,962,265.77	$ 12,384.06	1,459	$ 8,095,432.59	$ 12,591.18	1,484	$ 8,234,148.02	$ 12,806.93	**$ 32,170,904.45**
Total	**195,580**	**$ 33,237,804.14**	**$ 1,687,856.60**	**197,222**	**$ 33,562,988.76**	**$ 1,702,027.07**	**198,879**	**$ 33,889,280.99**	**$ 1,716,326.99**	**200,553**	**$ 34,223,110.23**	**$ 1,730,773.62**	**$ 141,750,168.41**

Projected Year 2

Medicaid Eligibility Group (MEG)	Total Projected Year 2 Member Months (P2)	P2 Projected PMPM Costs from Appendix D5 (Totals weighted on Projected Year 2 Member Months)					Total PMPM Projected Service Costs (Column H-G)
		Total PMPM State Plan Service Cost Projection	Total PMPM Incentive Cost Projection	Total PMPM 1915(b)(3) Service Cost Projection	Total PMPM Administration Cost Projection	Total PMPM Projected Waiver Costs	
AFDC	555,078	$ 47.76	$ -	$ 4.10	$ 9.27	$ 61.13	$ 51.86
Blind/Disabled and Foster Children	167,339	$ 425.00	$ -	$ 68.21	$ 9.27	$ 502.47	$ 493.21
Aged	90,653	$ 34.50	$ -	$ 2.87	$ 9.27	$ 46.64	$ 37.38
CAP-MR	6,193	$ 5,419.19	$ -	$ 368.12	$ 9.27	$ 5,796.57	$ 5,787.30
Total	**819,263**						
P2 Weighted Average PMPM Casemix for P2 (P2 MMs)		**$ 163.95**	**$ -**	**$ 19.81**	**$ 9.27**	**$ 193.03**	

Medicaid Eligibility Group (MEG)	Q5 Quarterly Projected Costs			Q6 Quarterly Projected Costs			Q7 Quarterly Projected Costs			Q8 Quarterly Projected Costs			Total P2 Projected Waiver Costs
	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	
AFDC	136,705	$ 7,089,694.12	$ 1,266,647.37	138,072	$ 7,160,588.47	$ 1,279,313.38	139,453	$ 7,232,208.87	$ 1,292,109.11	140,848	$ 7,304,555.34	$ 1,305,034.56	**$ 33,930,151.23**
Blind/Disabled and Foster Children	41,398	$ 20,417,728.15	$ 383,575.35	41,688	$ 20,560,757.80	$ 386,262.36	41,980	$ 20,704,773.85	$ 388,967.90	42,273	$ 20,849,283.11	$ 391,682.71	**$ 84,083,031.22**
Aged	22,629	$ 845,780.49	$ 209,670.19	22,652	$ 846,640.14	$ 209,883.30	22,675	$ 847,499.78	$ 210,096.41	22,697	$ 848,322.05	$ 210,300.25	**$ 4,228,192.61**
CAP-MR	1,509	$ 8,733,040.25	$ 13,981.72	1,535	$ 8,883,510.13	$ 14,222.62	1,561	$ 9,033,980.01	$ 14,463.53	1,588	$ 9,190,237.19	$ 14,713.70	**$ 35,898,149.15**
Total	**202,241**	**$ 37,086,243.01**	**$ 1,873,874.63**	**203,947**	**$ 37,451,496.53**	**$ 1,889,681.66**	**205,669**	**$ 37,818,462.52**	**$ 1,905,636.95**	**207,406**	**$ 38,192,397.69**	**$ 1,921,731.21**	**$ 158,139,524.21**

P Q R S T U

Quarterly CMS Targets for RO CMS-64 Review Renewal

State: North Carolina

Projection for Upcoming Waiver Period

Projections for RO CMS-64 Certification - Aggregate Cost

Projected Year 1 4/1/2007 through 3/31/2008

Waiver Form	Medicaid Eligibility Group (MEG)	Q1 Quarterly Projected Costs Quarter Ending (QE) 6/30/2007	Q2 Quarterly Projected Costs Quarter Ending (QE) 9/30/2007	Q3 Quarterly Projected Costs Quarter Ending (QE) 12/31/2007	Q4 Quarterly Projected Costs Quarter Ending (QE) 3/31/2008
64.9 Waiver Form	AFDC	$ 6,226,537.57	$ 6,288,816.69	$ 6,351,711.97	$ 6,415,223.40
64.9 Waiver Form	Blind/Disabled and Foster Children	$ 18,414,889.28	$ 18,543,879.04	$ 18,673,326.21	$ 18,804,145.61
64.9 Waiver Form	Aged	$ 767,278.33	$ 768,027.26	$ 768,810.23	$ 769,593.20
64.9 Waiver Form	CAP-MR	$ 7,829,098.96	$ 7,962,265.77	$ 8,095,432.59	$ 8,234,148.02
64.10 Waiver Form		$ 1,687,856.60	$ 1,702,027.07	$ 1,716,326.99	$ 1,730,773.62

Projected Year 1 4/1/2008 through 3/31/2009

Waiver Form	Medicaid Eligibility Group (MEG)	Q5 Quarterly Projected Costs Quarter Ending (QE) 6/30/2008	Q6 Quarterly Projected Costs Quarter Ending (QE) 9/30/2008	Q7 Quarterly Projected Costs Quarter Ending (QE) 12/31/2008	Q8 Quarterly Projected Costs Quarter Ending (QE) 3/31/2009
64.9 Waiver Form	AFDC	$ 7,089,694.12	$ 7,160,588.47	$ 7,232,208.87	$ 7,304,555.34
64.9 Waiver Form	Blind/Disabled and Foster Children	$ 20,417,728.15	$ 20,560,757.80	$ 20,704,773.85	$ 20,849,283.11
64.9 Waiver Form	Aged	$ 845,780.49	$ 846,640.14	$ 847,499.78	$ 848,322.05
64.9 Waiver Form	CAP-MR	$ 8,733,040.25	$ 8,883,510.13	$ 9,033,980.01	$ 9,190,237.19
64.10 Waiver Form		$ 1,873,874.63	$ 1,889,681.66	$ 1,905,636.95	$ 1,921,731.21

V W X Y Z AA AB AC AD AE AF AG AH AI

Quarterly CMS Targets for RO Cost-Effectiveness Monitoring

State: North Carolina

Projection for Upcoming Waiver Period

Worksheet for RO PMPM Cost-Effectiveness Monitoring

Projected Year 1

Waiver Form	Medicaid Eligibility Group (MEG)	State Completion Section - For Waiver Submission P1 Projected PMPM From Column I (services) From Column G (Administration)
64.9 Waiver Form	AFDC	$ 47.40
64.9 Waiver Form	Blind/Disabled and Foster Children	$ 457.41
64.9 Waiver Form	Aged	$ 34.04
64.9 Waiver Form	CAP-MR	$ 5,548.62
64.10 Waiver Form	All MEGS	$ 8.63

Projected Year 1

Waiver Form	Medicaid Eligibility Group (MEG)	RO Completion Section - For ongoing monitoring Q1 Quarterly Actual Costs Member Months Actuals for QE 06/30/07	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	RO Completion Section - For ongoing monitoring Q2 Quarterly Actual Costs Member Months Actuals for QE 09/30/07	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	RO Completion Section - For ongoing monitoring Q3 Quarterly Actual Costs Member Months Actuals for QE 12/31/07	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	RO Completion Section - For ongoing monitoring Q4 Quarterly Actual Costs Member Months Actuals for QE 03/31/08	Actual Aggregate Waiver Form Costs	Actual PMPM Costs
64.9 Waiver Form	AFDC			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.9 Waiver Form	Blind/Disabled and Foster Children			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.9 Waiver Form	Aged			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.9 Waiver Form	CAP-MR			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.10 Waiver Form	All MEGS			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!

Projected Year 1

Waiver Form	Medicaid Eligibility Group (MEG)	State Completion Section - For Waiver Submission P1 Projected PMPM From Column I (services) From Column G (Administration)
64.9 Waiver Form	AFDC	$ 51.86
64.9 Waiver Form	Blind/Disabled and Foster Children	$ 493.21
64.9 Waiver Form	Aged	$ 37.38
64.9 Waiver Form	CAP-MR	$ 5,787.30
64.10 Waiver Form	All MEGS	$ 9.27

Projected Year 1

Waiver Form	Medicaid Eligibility Group (MEG)	RO Completion Section - For ongoing monitoring Q5 Quarterly Actual Costs Member Months Actuals for QE 06/30/08	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	RO Completion Section - For ongoing monitoring Q6 Quarterly Actual Costs Member Months Actuals for QE 09/30/08	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	RO Completion Section - For ongoing monitoring Q7 Quarterly Actual Costs Member Months Actuals for QE 12/31/08	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	RO Completion Section - For ongoing monitoring Q8 Quarterly Actual Costs Member Months Actuals for QE 03/31/09	Actual Aggregate Waiver Form Costs	Actual PMPM Costs
64.9 Waiver Form	AFDC			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.9 Waiver Form	Blind/Disabled and Foster Children			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.9 Waiver Form	Aged			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.9 Waiver Form	CAP-MR			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.10 Waiver Form	All MEGS			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!

Cost Effectiveness Summary Sheet Renewal Waiver

State: North Carolina

Retrospective Period

Medicaid Eligibility Group (MEG)	R1 Member Months	R1 PMPM State Plan Service Costs	R1 PMPM Incentive Costs	R1 PMPM 1915(b)(3) Service Costs	R1 PMPM Administration Costs	R1 PMPM Total Actual Waiver Costs
		R1 Per Member Per Month (PMPM) Costs				
AFDC	477,167	$ 32.64	$ -	$ 3.24	$ 7.11	$ 42.99
Blind/Disabled and Foster Children	154,145	$ 330.87	$ -	$ 53.85	$ 7.11	$ 391.84
Aged	90,220	$ 52.21	$ -	$ 2.27	$ 7.11	$ 61.59
CAP-MR	4,840	$ 4,969.27	$ -	$ 290.64	$ 7.11	$ 5,267.03
Total	**726,372**					
R1 Overall PMPM Casemix for R1 (R1 MMs)		**$ 131.25**	**$ -**	**$ 15.77**	**$ 7.11**	**$ 154.14**
Total R1 Expenditures						**$111,961,068**

Medicaid Eligibility Group (MEG)	R2 Member Months	R2 PMPM State Plan Service Costs	R2 PMPM Incentive Costs	R2 PMPM 1915(b)(3) Service Costs	R2 PMPM Administration Costs	R2 PMPM Total Actual Waiver Costs	Overall R1 to R2 Change (annual)
		R2 Per Member Per Month (PMPM) Costs (Totals weighted on Retrospective Year 2 Member Months)					
AFDC	126,245	$ 39.76	$ -	$ 3.56	$ 7.22	**$ 51.36**	**19.5%**
Blind/Disabled and Foster Children	39,151	$ 365.04	$ -	$ 59.19	$ 7.22	**$ 432.28**	**10.3%**
Aged	22,449	$ 28.52	$ -	$ 2.49	$ 7.22	**$ 39.05**	**-36.6%**
CAP-MR	1,319	$ 5,000.72	$ -	$ 319.46	$ 7.22	**$ 5,328.22**	**1.2%**
Total	**189,164**						
R2 Weighted Average PMPM Casemix for R1 (R1 MMs)		**$ 140.45**	**$ -**	**$ 17.34**	**$ 7.22**	**$ 165.83**	**7.6%**
R2 OVerall PMPM Casemix for R2 (R2 MMs)		**$ 140.34**	**$ -**	**$ 17.15**	**$ 7.22**	**$ 165.53**	**7.4%**
Total R2 Expenditures						**$31,312,438**	

Total Previous Waiver Period Expenditures (Casemix for R1 and R2)	**$143,273,506**
Total Difference between Projections and Actual Waiver Cost for Previous Waiver Period	**$29,645,380**

Prospective Period

Cost Effectiveness Summary Sheet Renewal Waiver

State: North Carolina

Medicaid Eligibility Group (MEG)	Projected Year 1 Member Months (P1)	P1 Projected PMPM Costs (Totals weighted on Projected Year 1 Member Months)					Overall R2 to P1 Change (annual)
		P1 PMPM State Plan Service Cost Projection	P1 PMPM Incentive Cost Projection	P1 PMPM 1915(b)(3) Service Cost Projection	P1 PMPM Administration Cost Projection	P1 PMPM Projected Waiver Costs	
AFDC	533,420	$ 43.58	$ -	$ 3.82	$ 8.63	$ 56.03	9.09%
Blind/Disabled and Foster Children	162,734	$ 393.88	$ -	$ 63.53	$ 8.63	$ 466.04	7.81%
Aged	90,291	$ 31.37	$ -	$ 2.68	$ 8.63	$ 42.67	9.28%
CAP-MR	5,789	$ 5,205.75	$ -	$ 342.87	$ 8.63	$ 5,557.25	4.30%
Total	**792,234**						
P1 Weighted Average PMPM Casemix for R2 (R2 MMs)		**$ 150.62**	**$ -**	**$ 18.41**	**$ 8.63**	**$ 177.66**	**7.33%**
P1 Weighted Average PMPM Casemix for P1 (P1 MMs)		**$ 151.86**	**$ -**	**$ 18.43**	**$ 8.63**	**$ 178.92**	**8.09%**
Total Projected Waiver Expenditures P1(P1 MMs)						**$141,750,168**	

Medicaid Eligibility Group (MEG)	Projected Year 2 Member Months (P2)	P2 Projected PMPM Costs (Totals weighted on Projected Year 2 Member Months)					Overall P1 to P2 Change (annual)
		P2 PMPM State Plan Service Cost Projection	P2 PMPM Incentive Cost Projection	P2 PMPM 1915(b)(3) Service Cost Projection	P2 PMPM Administration Cost Projection	P2 PMPM Projected Waiver Costs	
AFDC	555,078	$ 47.76	$ -	$ 4.10	$ 9.27	$ 61.13	9.10%
Blind/Disabled and Foster Children	167,339	$ 425.00	$ -	$ 68.21	$ 9.27	$ 502.47	7.82%
Aged	90,653	$ 34.50	$ -	$ 2.87	$ 9.27	$ 46.64	9.30%
CAP-MR	6,193	$ 5,419.19	$ -	$ 368.12	$ 9.27	$ 5,796.57	4.31%
Total	**819,263**						
P2 Weighted Average PMPM Casemix for P1 (P1 MMs)		**$ 162.99**	**$ -**	**$ 19.79**	**$ 9.27**	**$ 192.04**	**7.33%**
P2 Weighted Average PMPM Casemix for P2 (P2 MMs)		**$ 163.95**	**$ -**	**$ 19.81**	**$ 9.27**	**$ 193.03**	**7.88%**
Total Projected Waiver Expenditures P2 (P2 MMs)						**$158,139,524**	

Medicaid Eligibility Group (MEG)	Projected Year 1 and 2 Member Months (P1 +P2)	Overall R1 to P2 Change (daily)
AFDC	1,088,498	0.05%
Blind/Disabled and Foster Children	330,073	0.03%
Aged	180,944	-0.08%
CAP-MR	11,982	#DIV/0!
Total	**1,611,497**	

	R1	P2	
P2 Weighted Average PMPM Casemix for R1 (R1 MMs)	**$ 154.14**	**$ 192.04**	**0.03%**
P2 Weighted Average PMPM Casemix for P2 (P2 MMs)	**$156**	**$ 193.03**	**0.03%**
Total Projected Waiver Expenditures P2 + P1 (Casemix for P1 and P2)		**$299,889,693**	

Modify Line items as necessary to fit the MEGs of the program.

State Completion Sections: PMPM from previously approved waiver.

To modify the formulas as necessary to fit the length of the program, please ensure that Appendix D1 is completed entirely. The formulas will automatically update given this data.

Appendix D7. Summary

Row # / Column Letter | B | C | J | K | L | M | N

Cost Eff

Costs to be input below are from the prior waiver submission. Compare the prospective years from the prior waiver submission to the retrospective years of the current waiver submission.

Retrospective Period

Medicaid Eligibility Group (MEG)	R1 Member Months	P1 Per Member Per Month (PMPM) Costs from the prior waiver submission: P1 PMPM State Plan Service Costs	P1 PMPM Incentive Costs	P1 PMPM 1915(b)(3) Service Costs	P1 PMPM Administration Costs	P1 PMPM Total Actual Waiver Costs
AFDC	477,167	$ 36.71	$ -	$ 3.24	$ 6.79	$ 46.74
Blind/Disabled and Foster Children	154,145	$ 449.30	$ -	$ 53.85	$ 6.79	$ 509.94
Aged	90,220	$ 67.64	$ -	$ 2.27	$ 6.79	$ 76.70
CAP-MR	4,840	$ 5,424.55	$ -	$ 290.64	$ 6.79	$ 5,721.98
Total	**726,372**					
R1 Overall PMPM Casemix for R1 (R1 MMs)		**$ 164.01**	**$ -**	**$ 15.77**	**$ 6.79**	**$ 186.57**
Total R1 Expenditures		**Total Previous P1 Projection using R1 member months**				**$135,521,744**

Medicaid Eligibility Group (MEG)	R2 Member Months	P2 Per Member Per Month (PMPM) Costs from the prior waiver submission: P2 PMPM State Plan Service Costs	P2 PMPM Incentive Costs	P2 PMPM 1915(b)(3) Service Costs	P2 PMPM Administration Costs	P2 PMPM Total Actual Waiver Costs
AFDC	126,245	$ 41.50	$ -	$ 3.56	$ 7.22	$ 52.28
Blind/Disabled and Foster Children	39,151	$ 470.27	$ -	$ 59.19	$ 7.22	$ 536.68
Aged	22,449	$ 50.85	$ -	$ 2.49	$ 7.22	$ 60.57
CAP-MR	1,319	$ 6,061.31	$ -	$ 319.46	$ 7.22	$ 6,387.99
Total	**189,164**					
R2 Weighted Average PMPM Casemix for R1 (R1 MMs)						
R2 OVerall PMPM Casemix for R2 (R2 MMs)		**$ 173.33**	**$ -**	**$ 17.15**	**$ 7.22**	**$ 197.70**
Total R2 Expenditures		**Total Previous P2 Projection using R2 member months**				**$37,397,142**

Total Previous Waiver Period Expenditures (Casemix for R1 and R2)		**$172,918,886**
Total Difference between Projections and Actual Waiver Cost for Previous Waiver Period		

Prospective Period

State of North Carolina **Appendix D7. Summary**

Row # / Column Letter	B	C	J	K	L	M	N
2		**Cost Eff**					
3							

Medicaid Eligibility Group (MEG)	Projected Year 1 Member Months (P1)
AFDC	533,420
Blind/Disabled and Foster Children	162,734
Aged	90,291
CAP-MR	5,789
Total	**792,234**
P1 Weighted Average PMPM Casemix for R2 (R2 MMs)	
P1 Weighted Average PMPM Casemix for P1 (P1 MMs)	
Total Projected Waiver Expenditures P1(P1 MMs)	

Medicaid Eligibility Group (MEG)	Projected Year 2 Member Months (P2)
AFDC	555,078
Blind/Disabled and Foster Children	167,339
Aged	90,653
CAP-MR	6,193
Total	**819,263**
P2 Weighted Average PMPM Casemix for P1 (P1 MMs)	
P2 Weighted Average PMPM Casemix for P2 (P2 MMs)	
Total Projected Waiver Expenditures P2 (P2 MMs)	

Medicaid Eligibility Group (MEG)	Projected Year 1 and 2 Member Months (P1 +P2)	Overall R1 to P2 Change (annualized)
AFDC	1,088,498	**19.27%**
Blind/Disabled and Foster Children	330,073	**13.24%**
Aged	180,944	**-24.27%**
CAP-MR	11,982	**#DIV/0!**
Total	**1,611,497**	
P2 Weighted Average PMPM Casemix for R1 (R1 MMs)		**11.64%**
P2 Weighted Average PMPM Casemix for P2 (P2 MMs)		**11.33%**
Total Projected Waiver Expenditures P2 + P1 (Casemix for P1 and P2)		

Modify Line items as necessary to fit the MEGs of the program.

State Completion Sections: PMPM from previously approved waiver.

To modify the formulas as necessary to fit the length of the program, please ensure that Appendix D1